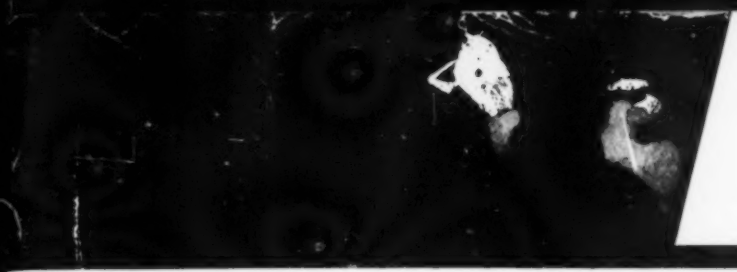


January, 1957

Canadian Hospital

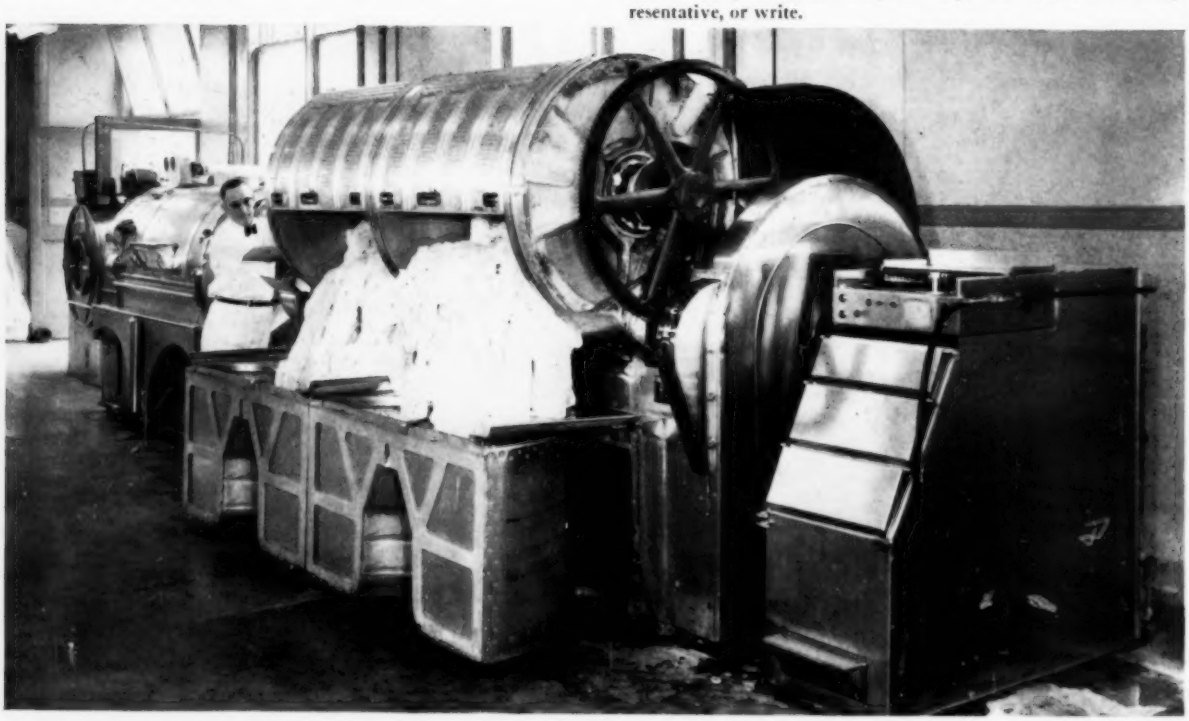
- Let's look at education
- Blue Cross as a social force
- Program to prevent infection
- Hospital challenge of the future
- Inclusive rates for Manitoba hospitals
- Nursing research at Notre-Dame, Montreal

Canadian Hospital Association

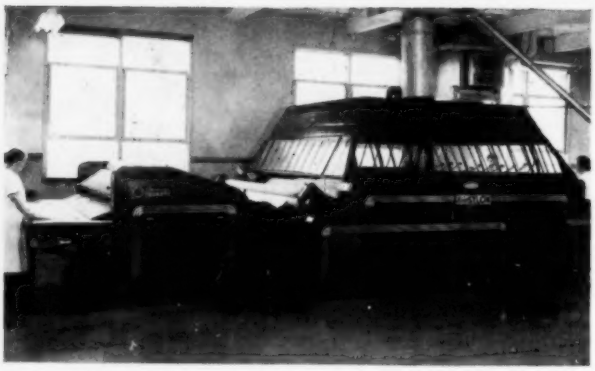
Report from Brantford General Hospital, Brantford, Ontario

Laundry costs down $600 per week with modern Canadian labor-saving equipment

Now, at the 378-bed Brantford General Hospital, pushbuttons handle former backbreaking laundry chores—thanks to new Canadian equipment. Automatic controls regulate work, practically eliminate manual operations. This adventure into modern, efficient laundry techniques has paid handsome dividends. Production is up 40%—weekly volume approaches 11 tons. At the same time, labor costs have dropped *$500 per week!* Added to this is a $50 weekly savings in supplies, better quality work, improved working conditions and faster return of linens to service. This is one example of what Canadian laundry planning and automatic machinery can do. For complete information, contact your nearest Canadian representative, or write.



Press buttons and 350 pounds of washed work tumble automatically into waiting containers of Notrux Extractor. These Cascade Unloading Washers, equipped with Full-Automatic Controls, now in use at Brantford General Hospital, are the ultimate in labor-saving equipment. The controls automatically perform 59 separate operations of the washing cycle—without attention.



Automatic folding of all linens reduces operating personnel and increases flatwork ironer production in Brantford General Hospital's efficiently planned laundry. Trumatic folder *(left)*, at delivery end of 8-Roll Super-Sylon Flatwork Ironer, automatically folds both large and small pieces, neatly and uniformly, at highest ironing speeds.

Canadian

The Canadian Laundry Machinery Company, Ltd.
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WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Edmonton, Vancouver

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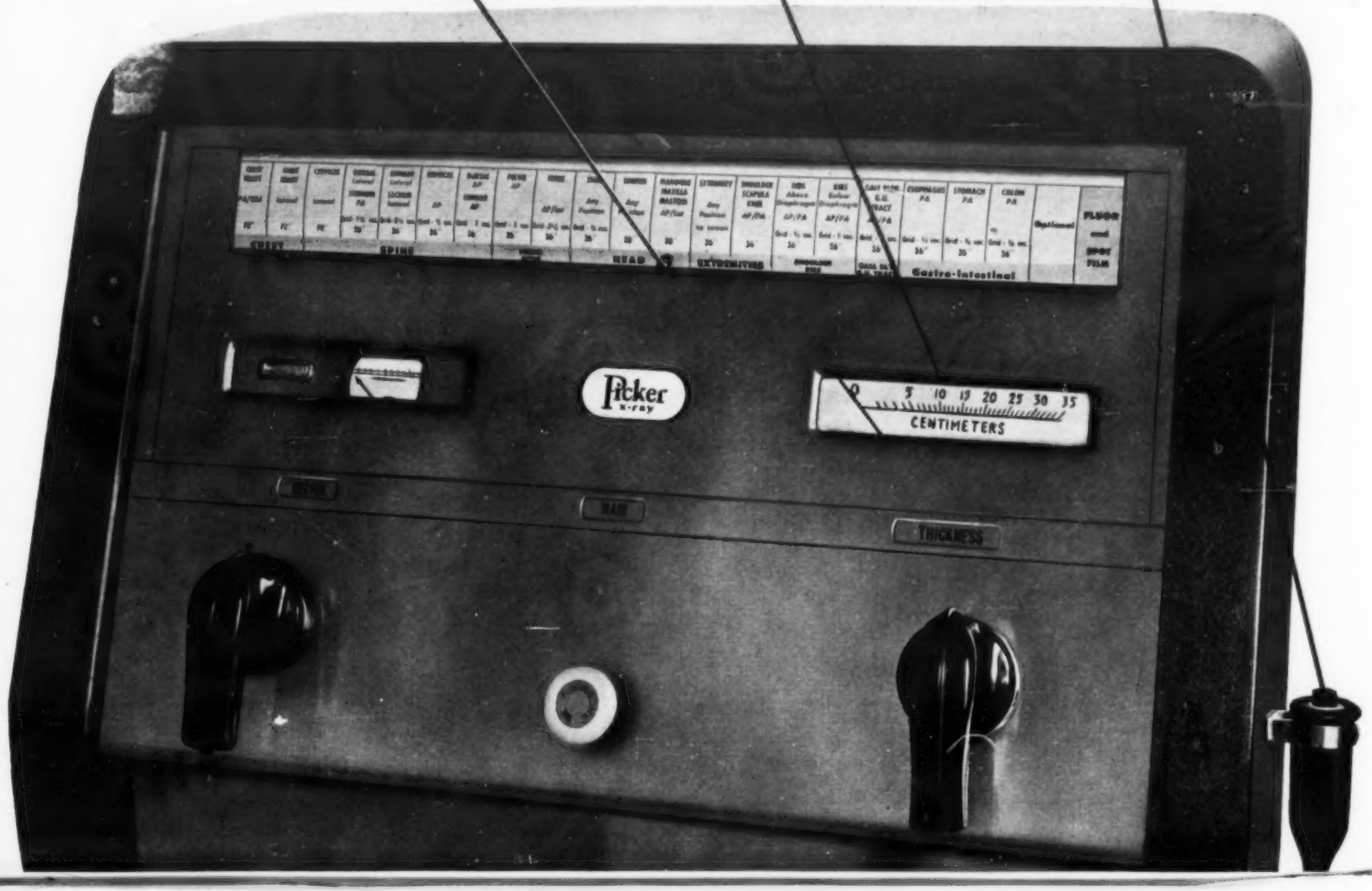

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Notes About People

Priscilla Campbell Retires

Administrator of Public General Hospital, Chatham, Ont., since 1922, Priscilla Campbell, R.N., has resigned her position and is planning to retire. During her 35 years with the hospital she has seen six building programs transform the institution. She received her nursing training at the Royal Victoria Hospital in Barrie and is a graduate of the Post-Graduate College of Nursing, London, England. Miss

Priscilla Campbell

Campbell has held many important positions in hospital and nurses' associations in this country. She is a past president of the District No. 1, Registered Nurses' Association, and of the Council of Nursing Education, Province of Ontario. She also helped to organize and became first president of the Regional Hospital Council, Districts 1 and 2. In 1946 Miss Campbell was elected president of the Ontario Hospital Association, an organization in which she has always taken an active interest. She has served for many years as a member of its board of directors and has been a member and chairman of innumerable committees. A member of the American College of Hospital Administrators since 1942, Miss Campbell is also a life member of the American Hospital Association.

Appointments at Winnipeg General

Two appointments to the staff of the Winnipeg General Hospital, Winnipeg, Man., have been announced recently. Dr. J. C. Wong has been appointed assistant administrator from October 1. He graduated in medicine from the University of Singapore, took a course in public health at Yale and was assistant to the superintendent of the University Hospital, Saskatoon, before coming to Winnipeg. Dr. Morgan Wright of the Manitoba Public Health Department assumed the position of clinical pathologist at the same hospital.

David Perlman

Dr. David Perlman, chief anaesthetist at the New Mount Sinai Hospital, Toronto, Ont., died recently after an illness of several months. Dr. Perlman graduated in medicine from the University of Toronto in 1918. A member of the Academy of Medicine and of the American, Canadian, and Ontario Medical Associations, Dr. Perlman had done much current research in anaesthesia and analgesia and was the author of several articles in medical journals.

At Calgary General

Elizabeth Forbes, director of the medical records department of the Calgary General Hospital, Calgary, Alta., was recently appointed administrative assistant at the hospital.

Retires After 38 Years' Service

J. A. Fraser, assistant director of the Royal Victoria Hospital, Montreal, P.Q., has retired after 38 years' service with the hospital. Mr. Fraser joined the hospital staff in 1919 as an accountant, later becoming office manager. He has held his present position since 1947.

A.C.H.A. Fellow

George Masters

We regret that, through an inadvertent error, we omitted the name and portrait of George E. Masters from our pages on the A.C.H.A. honours for 1956. Mr. Masters, who is administrator of the Royal Jubilee Hospital, Victoria, B.C., received a fellowship in September.

Receives A.H.A. Citation for Accomplishment

In December Judge John Milton George, Q.C., Morden, Manitoba, received a Citation of Accomplishment from the American Hospital Association at a dinner marking the end of his term, December 31, as a commissioner of the Joint Commission on Accreditation of Hospitals.

The citation, which was voted by the association's board of trustees, noted that Judge George had been a commissioner since the establishment of the accrediting body in 1952. It praised him for having "served with distinction in the development of this voluntary program for the improvement of patient care" and for "his many other activities in the public behalf".

Judge George received his bachelor of laws degree from the University of Manitoba in 1911. His interest in hospitals began in 1922 when he took an active part in establishing a hospital at Deloraine and served on its board of trustees for 20 years. Since then he has been connected with Morden District Hospital. He has been chairman of the Health Advisory Commission of Manitoba and has been president of the Associated Hospitals of Manitoba.

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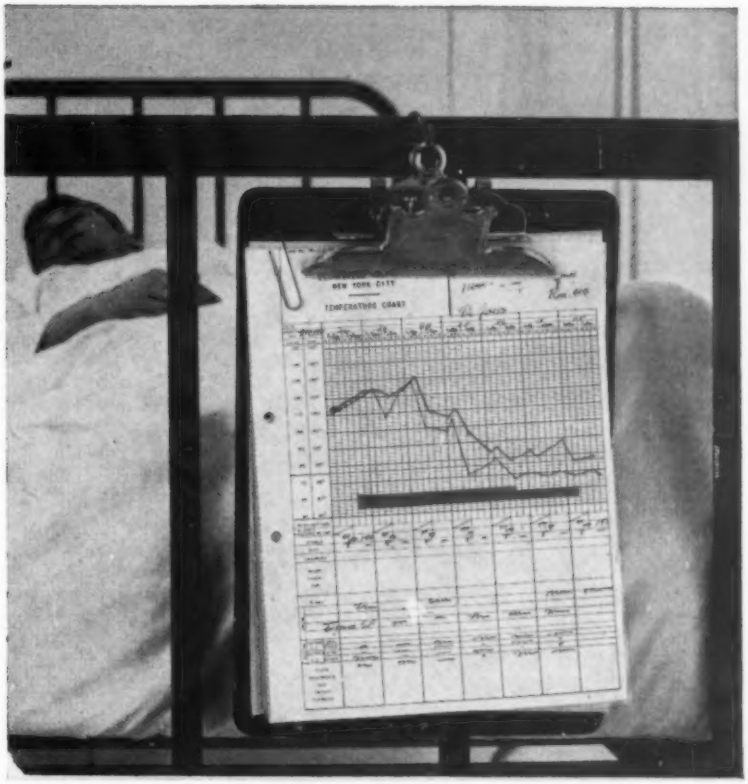
CLINICALLY, SIGMAMYCIN OVERCOMES INFECTIONS RESISTANT TO OTHER ANTIBIOTICS



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1. Winton, S. S., and Chesrow, E. J. : Paper presented at the Fourth Annual Antibiotic Symposium, Washington, October 17 - 19, 1956.

Notes About People

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Judge George has also served as chairman of the South Central Regional Hospital Council; as a member of the Practical Nurses' Council of Manitoba; chairman of a council appointed to study the present day problems of the nursing profession; and as chairman of the by-laws committee of the C.H.C. He was made an honorary life member of the American Hospital Association in 1948 and an honorary member of the North Dakota Hospital Association in 1954.

New Assistant Medical Director

Dr. Leslie Mandel, M.D., M.R. C.P. has been appointed assistant director of medical services at the Riverview Hospital, Windsor, Ont. Dr. Mandel received the degrees of Bachelor of Medicine and of Surgery from the University of Liverpool, Liverpool, England. He continued his studies in internal medicine from 1946 to 49 when he became a member of the Royal College of Physicians, London, and in 1953 received his M.D. degree. Dr. Mandel will join in the program being undertaken at Riverview Hospital to develop the institution as a rehabilitation and chronic disease research centre.

New Surgeon-in-chief

Hotel Dieu Hospital, Perth, N.B., recently announced the appointment of Dr. G. F. W. Moore as surgeon-in-chief. Dr. Moore attended the University of New Brunswick and received his M.D. degree in 1948 from McGill University. After returning to Montreal in 1952 for post graduate work, he held a resident appointment in teaching hospitals of McGill University and in 1954 accepted a surgical appointment at Hammersmith Hospital, London Post-Graduate School of Medicine, London, England, where he did further work in general surgery and related subjects.

Staff Changes at Hotel Dieu, Windsor

R. E. Mann, who has been office manager and acting superintendent at Alexandra Hospital, Ingersoll, has gone to Windsor to assume the duties of personnel supervisor at the Hotel Dieu Hospital. Rev. Sister E. Bachand has replaced Rev. Sister Cazabon as bursar of the same hospital.

New Appointments

Leaving the Nutrition Division of the Dept. of National Health and Welfare, Ottawa to accept new positions are: Helen Sackville, who has been appointed emergency feeding officer with Welfare Services, Civil Defence Division, Department of National Health and Welfare, Ottawa; and Doris Norman, who will become nutritionist in the outpatients' clinic at the Montreal General Hospital, Montreal.

New Matron at Devon

Clara Albers recently took over her new duties as matron in charge of the Devon Civic Hospital, Devon, Alta. Miss Albers is a graduate of the Camrose Hospital and took a post graduate course in operating

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Notes About People
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room technique at St. Michael's Hospital, Toronto, Ont.

- Mrs. I. King is now matron of the Red Cross Outpost Hospital, Blue River, B.C., succeeding Phyllis Pyebone who has returned to England.
- Dr. Earl R. Lee has been appointed staff radiologist at the Carleton Memorial Hospital, Woodstock, N.B.
- Frederick J. Harrop has recently been appointed accountant at the Kitchener-Waterloo General Hospital, Kitchener, Ont.

Doctors and Dentists Discuss Civil Defence Problems

Some 45 doctors and dentists from across Canada conferred at the Canadian Civil Defence College at Arnprior, from November 19 to 23, to consider the multiple health problems arising from the possibility of atomic attack in event of a national emergency.

Those attending the course were selected by municipal and provincial governments, by industry and by professional organizations across the country. In addition, there were representatives of the medical and dental officers of the Armed Forces and certain other physicians selected by the federal government.

Subjects covered during the week's conference included the probable effects of atomic, chemical, and biological weapons on the North American continent; contamination by radioactive material; biological warfare defence; psychological and psychiatric problems in catastrophe situations; the supply of medical and technical material in the event of a national emergency; and the roles of medical and dental practitioners, pharmacists, professional nurses, and ancillary medical personnel in civil defence.

A selected group of speakers gave particular attention to the care and treatment of mass casualties, covering such specialist subjects as thermal injuries in atomic warfare, wounds and fractures, hospital management, public health problems, and anaesthesia and analgesia in mass casualty management. One of the highlights of the course was an actual demonstration of an advanced treatment centre using realistically simulated casualties to add authenticity to the presentation.

Besides speakers from the Federal Civil Defence Health Services' staff, participants were present from university faculties, governmental scientific institutions, and consultants and specialists in particular fields associated with the civil defence health program. There was also professional representation from the Defence Research Board; Department of Agriculture; the Atomic Energy Commission; Canadian Red Cross; Ontario Department of Health; Canadian Army; Royal Victoria Hospital, Montreal; the Universities of Toronto and Western Ontario; and the Canadian Hospital Association.

The course was under the direction of Dr. K. C. Charron, director of Civil Defence Health Services, Ottawa. He was assisted by Dr. F. C. Pace, Medical Consultant, Special Weapons Section, and Dr. G. E. Fryer, Medical Consultant, Civil Defence Health Services.

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Looking Ahead in 1957.

INSTITUTIONS, like individuals, at this season usually review the past twelve months' operation and look ahead for the coming year. The majority of hospital boards will be holding their annual meetings this month and, in addition to receiving reports on activities during 1956, they will be expressing the work of 1957 in terms of budgets. It is of benefit to look back, to review what we have accomplished and it is essential to look forward and plan for the future.

The list of things we would wish for our hospitals in 1957 are legion. There are many needs to be filled. Some are long-term and some are short-term projects. Some require capital funds, others are in the field of organization and human relations. Perhaps your greatest requirement is a more adequate plant, more trained staff or new equipment. Most administrators would like to see a more commensurate method of financing so that they would spend less time and worry over balancing the budget. Some would ask for a greater interest in accreditation, disaster planning, and a more general understanding on the part of all concerned of the functions of a hospital. We believe many nurses, particularly head nurses, would be willing to settle for more working space and adequate storage space for the many articles that are required in the day-to-day running of a ward. Not to be overlooked would be some place to store stretchers and wheel chairs!

Some things we would like require considerable sums of money and long periods of planning. However, if the coming year is not to be one in which a large building program is undertaken, there is still much that can be accomplished. If we resolve that this year our hospital will develop a more efficient organization, become a quieter and safer place for patients and staff, have more of the spirit of cooperation between all groups working in the institution and closer integration with the community—if we strive for these objectives and achieve some degree of success—then at the close of 1957 we shall be able to look back and know that it has been a year of great achievement.

Is Your Hospital Safety Conscious?

ACCIDENTS are unnecessary and preventable, economically wasteful, and disastrous in terms of human suffering and loss of life. With these ideas we can all agree—yet are we sufficiently safety conscious? Hospitals are called upon constantly to care for people who have been injured elsewhere—what about the accident rates in our own institutions?

In this mechanized and highly mobile era, our attitude towards accidents and safety measures to prevent them is the all important factor. It is not enough that the administrator is concerned over the safety record of his hospital. Safety is everybody's business! A planned program of safety education for everyone is required, the goals of which are the conditioning of the individual to function safely as a matter of course—as a habit. In considering such a project, three groups have to be kept in mind —the patient, employees, and the general public.

No hospital is too small to have an active safety program. In the small hospital, the administrator will take personal charge and be directly implicated in planning and supervising the course of action.

In a larger hospital, the superintendent may delegate this authority to the assistant administrator, a personnel director or the chief engineer. Regardless of who directs the plan, its success will depend in large measure upon the attitude of departmental heads and supervisory staff.

It is not sufficient that your hospital can meet basic requirements in providing protection against fire hazards, cross-infections, and falls; or that it is prepared to cope with power failure or a possible community disaster. It is not enough either that equipment be scientifically installed, adequately maintained, regularly inspected, and correctly operated. Beyond this, workers must know and observe standard rules of operation; what action is required in an emergency and that good housekeeping is a fundamental requirement of all safety.

Many hospitals have found it an advantage to establish a safety committee. In order that the group can function properly, it is necessary that certain statistics be available. These will include the number of patients who fall in the hospital, the number of employees who suffer accidents both minor and major and accidents to visitors in the hospital. It is an axiom that all accidents, regardless of how minor, should be reported in writing. It is only by periodic review of these reports that it can be determined if real progress is being made.

To set up a committee and to establish records is still not enough. Teaching employees how their work is to be done is of utmost importance. It must not be forgotten that with many classifications of employees, the turnover is great, and each new employee needs orientation, job instruction and supervision. A vital part of any orientation program and in-service education is safety indoctrination.

Follow-up is essential and includes inspection of conditions and work practices on an organized basis. Let us all resolve that 1957 will be a year in which our whole organization becomes more safety conscious.

Le patient est humain

ON a beaucoup parlé de l'hôpital comme institution communale faisant partie intégrale de la société, et de la nécessité que son oeuvre soit comprise du public. Ceci nous a fait reconnaître la valeur de bonnes relations avec le public, et beaucoup d'hôpitaux ont prévu actuellement des programmes à cette fin. Une grande part de l'importance accordée récemment à ces relations, ressort de l'augmentation des frais et du besoin de gagner l'appui de la communauté.

Il est essentiel, aujourd'hui, à cause de cette préoccupation du budget et des finances, d'accentuer l'aspect humain de l'activité de l'hôpital. On ne peut trop souvent répéter que le patient occupe une place de première importance dans l'activité de l'hôpital. Il faut examiner constamment l'hôpital du point de vue du patient—et nous mettre à sa place. Si vous suggérez à un employé d'hôpital que le patient n'occupe pas la place la plus importante dans la pensée du personnel, on va certainement vous mettre en doute. Et pourtant une grande partie de la routine journalière du patient ordinaire de l'hôpital le rend mal à l'aise, malheureux, et parfois rancunier. Nous sommes, nous-mêmes, généralement, si occupés avec "la routine" qui est devenue notre règle pour diriger l'institution et qui nous semble tout à fait normale, que nous perdons de vue l'effet de tout ce va-et-vient sur le patient.

Ceci ne veut pas dire que le sort du malade ne se soit pas amélioré au cours des années. Il était difficile, au début du siècle, de persuader au patient qu'il devait s'hospitaliser, et sa crainte n'était par déraisonnable. Grâce à une science de médecine progressive qui a fait beaucoup pour l'avancement technique de diagnoses et de traitements dans l'hôpital moderne, et qui a haussé le niveau d'éducation et du service d'infirmières, les traitements se sont beaucoup améliorés. Quoique nous devions nous vanter d'une plus grande sécurité disponible au patient aujourd'hui, nous ne devrions pas rester satisfaits. Il y a toujours le danger de stéréotyper notre attitude envers le patient. Le patient est considéré, de plus en plus, comme un groupe d'organismes et de systèmes à étudier ou comme un automate à être soigné suivant une routine fixe—ce qui lui paraît viser la convenance du personnel plutôt que ses propres soins thérapeutiques.

L'administrateur moyen reçoit, par lettre, plus de compliments que de critiques pour le service offert. Il se peut que la proportion soit si favorable qu'elle le berce d'un faux sens de sécurité et de l'idée que ceux qui font la critique sont irraisonnables. C'est une faiblesse humaine de vouloir protéger tout ce dont nous partageons la responsabilité; quand un patient se plaint, nous nous tenons tout de suite sur la défensive. Nous nous disons que la personne en question est d'une humeur acariâtre, ou bien nous oublions la plainte en face de problèmes plus pressants.

L'hôpital d'aujourd'hui, occupé à servir comme centre diagnostique et thérapeutique très actif, semble presque ignorer une de ses plus importantes fonctions—celle de rassurer les patients. Nous devrions reconnaître le fait qu'un malade demande le maximum de sympathie et de compréhension. Le patient en général est extrêmement craintif. Si ce n'est la peur de ne pas guérir, ce sont de petits ennuis, dont la plupart disparaîtraient si quelqu'un prendrait le temps de lui parler tranquillement.

Le personnel des hôpitaux sont aussi sympathiques et compréhensifs que tout autre groupe d'une communauté. Cependant, l'hôpital, avec le va-et-vient de tellement de gens, est ordinairement si affairé qu'il reste peu de temps pour le rencontre du personnel avec les patients. Ceux-ci ont peu d'occasions pour alléger leurs soucis. Fréquemment, quand l'occasion se présente, ils craignent de parler de peur d'être mal compris ou de peur qu'on tienne rancune.

Ce qu'il faut, aujourd'hui, c'est que le personnel supérieure reconnaisse que le patient est un être humain. Si l'administration s'en souviennent, ils ne cesseront pas dans leurs efforts pour assurer que tout le personnel soit imbu de la même idée. Le fonctionnement d'un hôpital demande plus qu'une bonne compréhension d'affaires et de finances. L'administrateur qui réussit vraiment dans sa tâche, ne juge pas son succès d'après les meilleurs chiffres inscrits dans le grand livre. Il consacre une part de son temps à sonder les besoins de ses patients—besoins non seulement physiques mais mentaux et spirituels. Faisant face à cette responsabilité, il trouvera dans ce champ son plus grand défi—la création et le maintien d'une organisation où le patient occupe toujours une place de première importance.

The Hospital Challenge of the Future

Malcolm G. Taylor, Ph.D.,
Department of Political Economy,
University of Toronto
Toronto, Ont.

THESE are exciting times. For hospital trustees, administrators and staff, there have probably not been such challenging days since the war years when Blue Cross was being developed. Now, as then, the future is filled with the potentialities of greater usefulness and each new day with meeting the challenge with concrete action. For hospital people it must be a source of great satisfaction that never before in our history has so much public attention in the local community, the province and the nation been centered on the role of the hospital.

The announcement of the federal government earlier this year that it would share in the costs of a national program of provincial hospital care plans and the recent establishment of the Ontario Hospital Services Commission are eloquent evidence of the public's interest in such services. These actions of nation-wide and province-wide significance are concrete evidence that in the last three or four decades the hospital has come to full flower as an indispensable institution of society. It performs for society three essential functions: care of the patient, education of the doctor, and the extension of knowledge regarding the management and prevention of disease. I refer to these functions only to point out four characteristics or features of the development of the hospital in the performance of them.

1. The advance of scientific medicine in the last few years and its concentration in the hospital has meant that hospital services are frequently a matter of life and death to the inidividual. In plain words, the product is so good that none can be without it. And it follows, therefore, as it has with every other essential service, that the public acting through its government, will inevitably become involved in its distribution. Fortunately, your interests, and those of the government acting for the people, are identical—a constantly improving product, made more readily available to those who need it.

2. The hospital is, in a sense, a monopolist. It has a monopoly of the services that it provides and, as with any monopoly that provides an essential service, this means

Malcolm G. Taylor

that you are, in fact, a *public* service. This has the effect of enlarging the scope of your responsibility, just as it demands that you lift the horizon of your imagination in the search for answers.

3. The rise of specialization of hospital functions. I wish merely to remind you, for the purpose of this analysis, of the distinction between diagnostic services, emergency treatment, treatment of the acutely ill, treatment of the chronically ill, rehabilitation, active medical care, active nursing care, and if you like, housekeeping.

4. The high cost of practically all these functions but, for our purposes here, particularly of the cost of the specialized functions of the active treatment general hospital. I do not imply that these services are unnecessarily or unjustifiably expensive, or that hospital care is not a better bargain now than it was. Good medical and hospital care are the soundest purchases we can make. I want simply to make the point that hospital services are expensive and we would do well constantly to remind ourselves of that fact and govern our actions accordingly.

High Esteem

The hospital has come to occupy this position of high esteem in contemporary society by virtue of two factors.

First, the creative intelligence and willingness to serve of countless doctors, nurses, researchers, and their assistants, of the administrators who create the institutional environment in which progress can be made, and of those who are frequently forgotten when it comes to handing out credit — the enlightened public-spirited trustee.

Second, it has been made possible by money—financial support poured in by philanthropists, voluntary donations, women's auxiliaries, religious orders, government grants and, not least, payment by patients.

In the 1930's all these sources proved inadequate for the increasingly important and increasingly expensive functions that the hospital had come to perform. Under the leadership of the hospitals themselves and other community-minded groups, there was evolved the now familiar pattern of prepayment for hospital services, a system that has proved a boon to both hospital and patient.

The impact of prepayment on hospitals is most evident, of course, in the provinces of B.C., Alberta, Saskatchewan, and Newfoundland. But an analysis of the most recent figures available for Ontario indicates the importance of voluntary prepayment where the circumstances are most favourable to its development, *i.e.* in a highly indus-

An address to the 32nd annual convention of the Ontario Hospital Association, Toronto, Ont., October 22, 1956.

trialized, highly urbanized society. Analysis of the sources of hospital revenue indicates that approximately 45 per cent of all general hospital revenue came from Blue Cross or insurance payments in 1954. No other province could show as high a percentage of income from voluntary prepayment, of course, but all would show signficant proportions.

As I have said, prepayment has proved a source of comfort to both hospitals and patients. For hospitals, it has provided a more stable source of income. For the consumer, it has had the great advantage of minimizing the economic consequence of illness by enabling people to pay for their illnesses while they are well rather than when they are sick.

There are two other possible results of prepayment, depending upon how hospitals establish their rates and how much of the bill the insurance benefit pays.

1. If the rate for hospital care includes the cost of research and education conducted by the hospital, and if the prepaid plan pays that rate in full, then the costs of education and research are no longer borne by only those who are sick, but by all who are insured.

2. If the rate for semi-private care includes a subsidy to help pay the cost of indigents in the public wards, then that subsidy is no longer paid only by those who are sick, but by all who are insured.

And this, surely, is as it should be, for the costs of research, education, and the care of the indigent should be borne by the entire community and not, as heretofore, by the sick. The sick generally have financial problems enough of their own.

There are other consequences of prepayment that I wish to mention. I referred earlier to the development of specialization of functions of treatment, classifying them broadly as diagnostic, active treatment including surgery, convalescent care, rehabilitation, active nursing care, occasional nursing care, housekeeping. Now these functions can be differentiated, in one respect, according to the kind and relative concentration of specialized services that each requires. From the financial point of view, one might say that the more specialized the skills and equipment needed and the greater the concentration of services, the greater will be the cost.

Our aim is the most rapid possible restoration of the patient to health, but, since our medical and economic resources are not unlimited, it is imperative that we always use the combination of resources that the patient requires, but no more of them than he requires, and for no longer than he requires. We must not compromise with quality; but we must always seek the least expensive way of meeting the patient's needs. While there are always exceptions, in general, a patient should never be treated in hospital if he can be treated in the doctor's office; he should never be admitted as an in-patient, if he can be treated as an out-patient; convalescing patients should not occupy $15 to $18 a day active treatment beds. With recognized exceptions, most chronically ill patients should not be in general hospital beds, not only because of the unnecessary expense, but because the organization of the general hospital is not orientated to their special needs. We might also agree that, if the patient can be adequately cared for at home, it is folly to treat him in hospital because to the costs of his treatment we must add the cost of room and board and what is, for him, an over-organized treatment service.

The present development of prepayment is creating many public pressures that are running counter to much that we know about the efficient use of funds, of trained technical staff, of expensive scientific equipment, and the development of a balanced system of treatment facilities. If proof of the effect of prepayment is required, one would need only to count the number of insured patients who are in bed who (a) should have obtained their x-rays or lab. tests or minor treatment in the out-patient department or a doctor's office; (b) should be convalescing at home or in a convalescent hospital; (c) are not getting the precise treatment because your hospital is not a rehabilitation clinic; (d) do not need medical care, but only routine nursing care; (e) if they had a visiting nurse or a visiting housekeeper, could be cared for at home.

Prepayment is a form of instalment buying. And it is part of the pattern of consumer spending that people buy more of those things for which they can pay on the instalment basis. They will substitute what they can buy on that basis for the things they really ought to have but for which no instalment mechanism exists.

One other aspect of this development of prepayment needs to be mentioned. It is that prepayment for hospital care has far outrun the prepayment for care in doctor's offices. While approximately nine million people are insured in some degree against the cost of hospital care, not more than 2 million are covered for office and home calls. Now I am aware of the insurance-minded approach that says that office and home calls are so inexpensive that no one needs to be insured against them. But, surely preventive health measures are so important, and the advantages of a preventive approach so obvious, that we should not set up any administrative or financial arrangements that encourage late rather than early treatment.

The consequence of these various points is that we are building too many active treatment units and not enough out-patient departments, rehabilitation centres, convalescent pavilions, long-term hospitals, and nursing homes. Moreover, we are not taking advantage of the fact that many patients have bed and board at home—and, often, a "built-in" nurse. We are building a lop-sided treatment service and the present system of prepayment is one of the major reasons. There are a host of other reasons, of course. Because of the miracles performed within its walls, the general hospital has caught the imagination of the public. Consequently, the community will make great contributions for general hospital extensions, but is not similarly motivated to provide these other facilities and services. Apparently they have less glamour. Perhaps government grants are not properly weighted to place the emphasis where it belongs. Perhaps not enough emphasis is being placed on the need for research and treatment of the degenerative diseases which will beset our aging population in greater volume. Perhaps we need to make larger salary differentials for public health nursing and visiting nursing.

The premise from which I am working is that we need and must develop a balanced program of hospital facilities and services if the esssential health needs of the Canadian people are to be met.

Balanced Health Programs

A total, balanced health program would include, of course:

"Snow Fence" by Dr. T. E. Brown, Lethbridge, Alberta.

(a) the services of physicians and surgeons in office and home, and of organized medical staffs in hospitals;

(b) diagnostic services in doctors' offices and in out-patient departments;

(c) active treatment general hospital services;

(d) rehabilitation centres;

(e) convalescent hospitals;

(f) facilities for the care of long-term patients; and

(g) home-care programs.

We are concerned here, of course, only with those aspects affecting hospitals and you may wonder why I mention all of these to you.

I present them here because, with the exception of medical services in office and home, it seems to me that a major share of responsibility for leadership in the development of a balanced program—facilities and services—lies with hospital associations and their member hospitals. The general hospital has become the community health centre from which a major share of health services radiate. While your primary interest and your first loyalty are to your own institution, it is now incumbent upon you to raise your sights far beyond the walls of your own institution. Even if we could ignore the service requirements, the stern economic realities (the costs of hospital care in the future) are now so apparent to all, that we must develop every alternative facility and service that makes admission and retention of many patients in active treatment beds unnecessary.

Responsibilities

What responsibilities constitute the challenge to you in the future? It seems to me that these responsibilities can be differentiated among a number of levels.

1. The responsibilities of the individual hospital. Your first task is a careful analysis of community needs and your relationship to those needs. With an expanding population, it is to be expected that treatment services needs will expand. But, mindful of the high costs of in-patient care, it is imperative that only true needs be met. We must not be stampeded by lists of patients waiting to get in. They may be waiting too long to get in only because too many are taking too long to get out. I think it would not be unfair to say that any hospital board that adds more active treatment beds without having analyzed critically its admitting policies, and its average length of stay, or without having exhausted all the possibilities of expanding out-patient facilities, and inaugurating a home care program, is not truly serving the public interest. Certainly it is not serving the interests of Blue Cross or of all other Blue Cross subscribers. A hospital board must recognize that it is committing the public every year to an additional expenditure of $4,000 to $5,000 for every bed it adds—or up to an additional half million dollars annually for every 100 beds it adds.

Individual hospitals must also examine the need for facilities for long-term care. Perhaps what is needed are rehabilitation services, or a convalescent pavilion, or a long-term unit in close proximity to active treatment services.

2. In many centres that have two or more hospitals, there appears to be a lack of co-ordinated planning, a lack of genuine co-operation among the hospitals in some of our cities that is a blot upon an otherwise magnificent record. The duplication of facilities, the gaps in services that result cannot be tolerated. Hospitals are not rival department stores competing for business. They are the custodians of a public trust. The public relies upon them.

3. At the provincial level, however, the need for leadership of a statesmanlike quality is equally great. Provincial hospital associations need to be more strongly organized than ever before, if they are to meet the demands of the future. As I have emphasized throughout, the most urgent need in this whole field of treatment services is the very simple prescription of providing the right facilities in the right place. The most feasible method of doing this so

(concluded on page 76)

A Program to Prevent Infection

and how it was established

DURING September and October of 1955 we became aware of an increased incidence of post operative wound infections. These, as far as could be determined, did not limit themselves to any one surgeon, group of surgeons or any one surgical unit. However, since almost simultaneous infections were found in patients who had a radical mastectomy, with suction applied post-operatively, it was decided to culture all the suction apparatus. Our fears were confirmed when positive cultures were obtained from supposedly clean apparatus. With these facts and the further knowledge of the increasing resistance of certain bacteria to our antibiotics, it was decided by the administration to have the chief surgeon and his staff make a preliminary investigation of this problem.

Preliminary Investigation

It was decided that cultures be taken from certain areas on the surgical floors. These areas should be ones which, though exposed to infections, should be considered reasonably free from pathogenic organisms. The nine cultures taken gave the following startling results:

1. Handle of dressing cart, floor 9—staph. aureus C.P. (coagulase positive);
2. Sink tap, room 914—staph. aureus C.P.;
3. Garbage can, floor 9—staph. aureus C.P.;
4. Wash basin, room 914—negative;
5. Handle of door, room 914—negative;
6. Handle of dressing cart, floor 8—staph. aureus C.P.;
7. Sink tap, room 830—E. Coli.;
8. Handle of door, room 830—staph. aureus C.P.;
9. Sink tap in room 828—pseudomonas.

These results sparked the next step in our activities. Meetings were held with the head nursing personnel, the general surgical staff, orthopaedic staff, and operating room personnel. The results were as listed here.

Nursing Personnel

Changes were made in the provision of dressings and instruments to nurses and doctors, and the use of the dressing cart as a means of transporting instruments and dressings (and infection!) was discontinued. (This was, of course, approved at our surgical staff meeting.)

A much stricter supervision of dressings and procedures performed by graduate nurses was instituted; and the head nurses on the floors are responsible for carrying this through.

Changes were made in the utility room adjacent to the nurses' stations on the surgical floors, resulting in the formation of a "dirty" area for contaminated materials and a "clean" area for sterile materials. The "clean" room washstand was provided with improved equipment for clean scrubbing.

The number of people entering the operating room suite was restricted to include only authorized personnel. The change from beds to stretcher-beds in the recovery room helped make this possible.

General Surgeons

Several general discussions as to possible sources of infection were held. The consensus of the surgical staff was that technique in the operating room must be critically examined and, if possible, sources of infection should be eliminated and controls instituted.

The staff were encouraged to be very careful in their abdominal preparations (internes were too often allowed to prepare abdomens without supervision), and to be vigilant at all times for possible sources of infection, breaks in sterile technique, et cetera.

The anaesthetists were instructed, through their chief, to be careful in their dress, wearing masks properly, et cetera.

Agreement to comply rigidly with all rules of the operating room, *e.g.* wearing shoe covers, wearing masks and hats properly, discouraging family doctors, et cetera, from breaking technique.

The surgeons were instructed by the chief of surgery to wear clean white coats when making rounds.

Orthopaedic Staff

A general discussion along similar lines to those with the general surgeons was held with the orthopaedic surgeons. They agreed to comply with all the suggested regulations. New rules regarding preoperative preparation for orthopaedic cases, shaving and sterile preps., were formulated.

Operating Room Personnel

The operating room supervisor pointed out that dust was entering the operating room via the air ducts, and filters were installed to combat this. These filters will be reconditioned regularly.

Decision to culture the throats of *all* the people who were even casually entering the operating room floor. This included surgeons of all specialties, nurses (operating room, recovery room), orderlies, pathologists, radiologists, technicians, secretaries. Thus far this report has the following results: three surgeons were found to have staph. aureus coagulase positive; no others were positive; later, all three were negative. It is intended that such a census be taken at least once every six months.

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Stricter supervision of nurses and interns (and surgeons) concerning sterile technique.

Nurses were urged to be very diligent in keeping out unauthorized persons, and watching for those entering operating rooms in improper outfits.

Infection Committee

During the period of investigation by the surgical and nursing staffs, it was noted on statistical data forwarded to the administrator, that the post-operative infection rate was slightly over 1 per cent. Although this was not considered to be alarming, the fact that the post-operative infection rate was over the 1 per cent standard made this an area for serious thought. The administrator, cognisant of the steps taken to reduce the post-operative infections occuring in the hospital, concluded that a co-ordinated effort by a representative group could formalize the activities in the preliminary investigations, and present an active program that could be followed. Subsequently an infection committee was formed.

The committee was composed of the assistant administrator, a senior member of the surgical staff, the chief pathologist, the director and assistant director of nursing and the operating room supervisor.

The purpose of this committee was to: (a) establish whether existing procedures were adequate for the control of post-operative infections; (b) suggest changes in procedures and methods where indicated; (c) educate the hospital staff in infection control.

On February 25, 1956, the first meeting of the infection committee was held, with the knowledge that specific preventive measures had been taken and that the post-operative infection rate had receded to acceptable levels. We might have been complacent at this point; however, it was realized that we were fighting, not only infection, but a particularly virulent and resistant strain causing infection which did not allow time for apathy.

Conferences with personnel from hospitals in Toronto and other cities revealed that: staphylococcus infection has increased in all hospitals to a varying degree; some people are alarmed about it and others not; in some centres the infection was so endemic that no one could ignore it; in one city it was already being discussed in the newspapers. Therefore, the infection committee felt that all precautions possible should be taken to prevent any widespread infection occuring in our hospital.

The following topics were discussed with a view to covering each area where rigid controls had to be maintained in the prevention of infections:

Scrubbing: soap used and technique.

Skin preparations: standards and techniques of preparing the skin for surgery; solutions used in skin preparation.

Reporting of infections: culturing and procedure of reporting.

Terminal cleansing of bedside equipment.

Waste and refuse disposal in the operating and case rooms and in the patients' wards.

Surgical masks: type used in normal circumstances and type for personnel having colds.

Mattress covers: the advisability of covering all mattresses with a material that could be washed down.

Intern education: orientation classes for interns regarding technique of scrubbing, gowning, draping, skin preparations, et cetera.

Dressing technique.

Isolation technique.

After the initial discussions it was decided by the infection committee that each item on the agenda should be analyzed for the purpose of defining what the present procedures were and to suggest improvements where pos-

The New Mount Sinai overcomes problems of infection

sible. Reports and recommendations were presented until each specific point, as outlined in the initial discussion, was resolved to the satisfaction of the group. The conclusions reached were as follows.

Results

Scrubbing

The soap previously used, after being cultured with virulent staphylococcus aureus, was discontinued and a green soap containing a higher percentage of hexachlorophene substituted. Exhaustive tests were made on various soaps available for scrubbing, until a mixture was found which, when diluted 1-in-1 provided a 2.5 per cent by volume solution of hexachlorophene and green soap. This solution when tested with cultured staphylococcus aureus (Robbins) showed a negative result. The factor of the non-irritability of the solution to the hands after repeated scrubbings, was also taken into consideration.

The technique of scrubbing was discussed with the surgical staffs, with the resultant formation of a "scrub-up" procedure. The "scrub-up" procedure was placed on a card 4 in. x 6 in. and placed above the scrub sinks throughout the operating and case rooms, as well as in scrub areas on the patient floors. The procedure is illustrated in the chart below:

Skin preparations

Standards and techniques were discussed with the surgical staff and it was the considered opinion of the group that each surgeon should focus increasing attention on methods used in skin preparation but that a specific procedure was not feasible or desirable at this time.

It was concluded that there are various preparations that are equally effective on skin preparations as cetavelin, zephiran chloride, tincture of merthiolate, to name a few, and that these should be provided on the surgeons' request.

Reporting of infections

It was found desirable that infections other than post-operative infections be included in reporting: patients with skin lesions; carbuncles or boils, and diarrhoea following antibiotic therapy. The procedure being followed, that of having the nurse on the ward fill out the infection slip and then forward a copy to the patient's chart, the chief of the service, the nursing office and the operating room supervisor, in cases of post-operative infections, was quite in order. The nursing office would also tabulate the incidence of infection into post-operative and others, and forward a monthly report to the administrator, unless frequency and type required immediate notification. The infection slip is illustrated here.

It was recommended by the infection committee and approved by the medical advisory council that it be mandatory for members of the medical staff to order cultures on all infections occurring in the hospital.

Terminal Cleansing of Bedside Equipment

Terminal cleansing of bedside equipment should be carried out by the central sterile supply, who should set aside a specific period each day for sterilization of bedside equipment. A sufficient supply of items to be on hand for immediate replacement was essential.

Garbage Disposal

A one-for-one exchange method of garbage disposal to be continued, *i.e.*, a cleansed garbage can replaces the used garbage disposal unit in the operating room, case room and floors each day, which alleviates the emptying of garbage in any area other than in the garbage room. The garbage room is located in the basement of the hospital with direct access to the incinerator.

Surgical Masks

The type of surgical mask that was requested contained a soft steel nose band that could be shaped around the nose, and would prevent droplet spray in cases of coughing or sneezing. This was approved by the group and a supply purchased.

An investigation was made into the types of surgical masks available for individuals having colds. Although a number were tested with varying results, we could not find a suitable mask which met our specifications, and at present our purchasing agent is in the process of collecting various types of masks for testing and selection by the surgical staff.

Infection Slip

Patient's Name .....
Doctor .....
Date of operation .....
Type of operation .....
Condition of incision .....
(state condition, which .....
dressing—first, second .....
et cetera, and by whom) .....
Date..... Head Nurse.....

Mattress Covers

After consulting various hospitals who are using mattress covers, and discussing the various pros and cons concerned, it was the opinion of the infection committee that mattress covers should be purchased. This would provide the nursing staff with an opportunity of washing down the covers in keeping with medical asepsis, as well as increase the life of the mattress. It was noted that special precautions should be taken in selecting material that would

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Scrub Technique with Brush — New Mount Sinai Hospital

Preliminary Wash

1. Wash each hand and arm vigorously with soap and water to elbow (one minute).
2. Cleanse nails with cuticle stick under running water (one minute).
3. Rinse.

Surgical Scrub

4. Scrub, using a circular motion, each of four surfaces of fingers, hand and arm to elbow (2½ minutes).
5. Rinse thoroughly under running water.
6. Repeat for second hand and arm (2½ minutes).
7. Dry hands on sterile towel, then arms.
8. Between glove changes—scrub for one minute.

Note: All scrubs are by clock.

Effective April 1st.

Manitoba Hospitals Adopt Inclusive Rates

EARLY in 1956, a committee on Inclusive Rates was established by the association to review the important question of current methods and practices of charging for hospital care and the possibility of the establishment of inclusive rates in Manitoba hospitals.

In its study of this question, the Committee made use of certain reference material, including the report of the Committee on Inclusive Rates established by the American Hospital Association some years ago. Various articles on the subject, published in hospital journals during the past number of years, were referred to, and the opinions of recognized authorities in hospital management were taken into consideration.

Methods of charging for hospital care are of paramount importance and any proposed change in current methods and practices must be carefully considered. In view of its importance to Manitoba hospitals, the Committee feels that they must be fully informed on the subject. This report will briefly review many aspects of the question as set out under the following sections:

History of hospital charges;
Development of inclusive rates;
Advantages of inclusive rates;
Objections raised to inclusive rates;
Typical inclusive rate plans reviewed;
Establishing an inclusive rate plan;
Public relations;
Professional relations; and
Recommendations of Committee.

History of Hospital Charges

During the past century, as hospitals began to engage in the care of the non-indigent sick, the rate structures were of a very simple form. The services then available were covered by a single charge usually stated as a rate per day or week, a simple inclusive rate system. Since that time, many new scientific procedures including laboratory, x-ray, pharmacy, anaesthesia and ancillary services were applied to hospital care, greater investment and higher operating costs resulting. These services created a problem in establishing rates to cover their cost. Many of them were used only by a few members of the medical staff and for a relatively small number of patients. This probably led to the practice of establishing a special charge to the patient receiving these "special services."

The hospital of today has evolved from that stage and the modern hospital now does not offer the patient a piece-meal or à la carte service, but actually offers a complete, highly integrated service, available at all times regardless of individual patient needs.

Procedures which have been termed "special" are now routinely provided for all patients who need them. So-called special services are so extensively used now that few hospital patients are ever cared for without receiving a considerable number of such services. In many cases the development of extra service charges has not borne any real relationship to the actual cost of providing the special services.

Development of Inclusive Rates

In many cases the heavy burden of charges on some patients has led to the development of a plan which takes into consideration the principle of leveling off peak charges and re-distributing them; and also to the introduction of the cost accounting principle so prevalent in business—that of including the stand-by or ready-to-serve charge as well as the actual cost of labour and supplies. An inclusive rate system in its fundamental form is merely a plan based on the well established principle of leveling off abnormally high peaks from the few patients' accounts by averaging those peaks among all other accounts. Our whole economic system is based on what may be called the "share the hazard" principle, and commonly includes the sharing of risks by the corporate form of business; sharing of life and property hazards through insurance; taxation system for governmental services; group hospitalization plans; and public utility rates.

All of these work in such a manner that unusual hazards will not fall too heavily on an individual or a small group, accomplishing this by spreading the risk over the large group.

This is the report of the Committee on Inclusive Rates to the Board of Directors of the Associated Hospitals of Manitoba. It was accepted and approved by that body on September 18, 1956, during its annual meeting.

Definition

An inclusive rate may be defined as a complete charge for a complete hospital service in a particular type of accommodation for a given length of stay. The only variables are length of stay and type of accommodation. An inclusive rate apportions all charges for essential and strictly hospital services and procedures incidental to the care of in-patients on a consistent, uniform basis, irrespective of actual utilization.

The concept of inclusive rates is based on the philosophy that hospital service is the one and only product that hospitals have to offer and each patient should have available to him every service in the hospital to the full extent to which he can benefit by it. The question of what services should generally be included or excluded in an inclusive rate will be considered later in this report.

The Hospital as an Entity

An inclusive rate recognizes the hospital as a functional entity of completely integrated services that are continuously available in accordance with public and professional demand. The day-rate plus extras system recognizes the individuality of the various therapeutic and diagnostic departments. The inclusive rate system attempts to correlate the charges for the particular service the patient actually receives with the "readiness to serve" expense incident to standing by and other equally important services required to meet unforeseen situations or contingencies.

Principles Involved

Principles and theories underlying inclusive rates are borne out by the fact that most procedures are similar from patient to patient and that variations are slight and inconsequential in comparison with the total volume of procedures. In hospitals today, from 60 to 65 per cent of all hospital service is already under an inclusive type of charge. The day rate currently represents an average charge for room, food, nursing care, resident medical staff services, orderly service, certain drugs and dressings, laundry, housekeeping, et cetera. This is an averaged-out charge and different patients require varying amounts of these services. It would then seem equally fair to average out so-called special services.

Under any system of charging, the hospital is concerned chiefly with the total volume of income as related to the total expense. This end can be readily accomplished under an inclusive rate system.

Establishment in Other Areas

Many hospitals in the United States and Canada today charge on an inclusive rate system. Government care plans in Saskatchewan and British Columbia have led to the charging on the basis of inclusive rates. On January 1st, 1956, hospitals in Alberta began charging on this basis with hospitals being divided into five groups. In addition, the experience of many hospitals in the United States charging on this basis has been related in various articles carried in hospital journals. As much as possible, the Committee has reviewed the experience in these hospitals and evaluated the results reported.

Advantages of Inclusive Rates

Advocates of an inclusive rate system offer the following as the advantages to be obtained under such a system:

A. From the Standpoint of Physician and Patient

Inclusive rates make possible an early and complete understanding between the patient, physician and the hospital on the matter of charges for care.

When the above is possible physicians should find it easier to arrange for the admission to hospitals since the cost can be largely pre-determined.

The inclusive rate method of levying hospital charges should result in improved patient-doctor relationship, improved patient-hospital relationship and improved hospital-doctor relationship.

Inclusive rates remove certain friction between physician and patient over a long list of minor charges which frequently are difficult to interpret.

Inclusive rates encourage a thorough diagnosis.

Patients are not denied necessary services because of their own or the physician's desire to keep the bill down.

The physician does not have to deny himself a modest fee in order to obtain additional diagnostic or therapeutic service for his patient.

Inclusive rates make it possible for the physician to discuss the cost of hospitalization at the time it is recommended.

B. From the Stand-point of the Hospital

The time-consuming operation of making out charge memoranda for countless small items is saved for today's already overworked staff.

The ability of the physician, patient and hospital to determine hospital charges for the patient, in advance, from a publicized schedule makes it possible for the patient to plan to meet the expense beforehand. If credit arrangements are necessary, these can be specifically set up at the time of admission on the basis of a known amount of money thereby reducing collection problems. An inclusive rate system reduces the risk of a catastrophic bill for a short stay.

Accounting and bookkeeping procedures can be simplified considerably.

The problem of late charges, or charges which come down from departments after the discharge of the patient, will be, for all practical purposes, eliminated.

An inclusive rate plan facilitates the matter of adjusting rates to cost, with a high degree of accuracy possible. Budgeting accurately is more easily accomplished and it is easier to adjust rates if costs fluctuate during an interim period.

Complaints, which invariably centre on extras, are largely eliminated.

The hospital has only one thing to sell and that is complete hospital care, not a series of unrelated personal and professional services.

Objections Raised

While there are a great many advantages to inclusive rates (outlined in the preceding section) it has been contended that certain disadvantages or problems may be encountered in their initiation and operation. These objections, together with comments thereon, follow.

The objection most frequently raised relates to the increased usage and abuse of special services. These are two different things but where one ends and the other begins is difficult to determine. A well-organized staff working in close harmony with the administration, and having sympathetic understanding of the institution's economic objectives, is of extreme importance in controlling abuse under inclusive rates. In practice, it has been found that any increase in cost is represented largely by supplies which, in relation to total expense, is relatively small.

It is not possible to measure financial effects of work done in special service departments, since a record of earnings by service units is not available. It is considered by many that the measuring of departmental efficiency in dollar volume is unsound and, in many hospitals, statistical data on departmental activity is kept in order to provide the administration data for control purposes. This type of statistical record could be extended to other special service departments where considered necessary.

The cost of operating departments such as x-ray, laboratories, and physiotherapy will be increased as departmental volume increases.

This is generally only true of the fluctuating items of labour and supplies. It is contended however, that the labour of technicians will seldom advance in proportion to the increase in usage, although if a department is already operating at capacity it might not be able to handle the increase without added personnel. Supplies constitute the principle items which will be affected and may be assumed to increase in direct proportion to usage. However, the increased cost of supplies in these departments is not great in relation to total costs.

Inclusive rates interfere with contract arrangements made with radiologists and possibly pathologists. This matter is discussed in another section of this report.

Patients may object to paying for "someone else's bill" preferring to pay only for services they actually receive.

This objection may be overcome

In the Belgian Congo

The "Administrateur Tordeur" dispensary in the "extra-customary" area of Thysville in the Belgian Congo, Africa. The urban centres that are governed by Congolese are called customary areas. Grateful inhabitants of the city wanted to give the name of a former administrator to this public building. Medical assistance is available now to all Congolese natives.

by pointing out to such a patient that he received many services that are not apparent to him and that there is an enormous load of expense behind the scenes. The cost of general service departments can be publicized and the cost of holding the various services in readiness for the use of *any* patient can be pointed out. This objection will be discussed further under the section on public relations.

What would be the attitude of Blue Cross, commercial insurance companies, governmental agencies, et cetera? If uniformity among hospitals as to the method of charging is achieved, it is felt that not only can this objection be overcome, but support for an inclusive rate plan will be forthcoming.

It has been said that inclusive rates are practical under conditions of a falling market but are difficult to maintain in a rising market.

As pointed out in the previous section it is the view of many that it is easier to keep accurate tabulation on total costs and consequently it is easier to make any necessary adjustment on an inclusive rate plan.

Typical Inclusive Rate Plans

In reviewing the possibility and practicability of an inclusive rate plan for Manitoba hospitals, the type of plan was given consideration. Various methods including varying rates for different types of care, reducing rates according to length of stay, surcharges, et cetera, were reviewed.

The most practical is felt to be the *Straight Line Plan* which consists of a daily rate based on total costs. In effect this amounts to the room rate plus average special services. The same rate applies to each day of the patient's stay.

It should be noted that in the three western provinces which have established inclusive rates, the straight line method is used.

Establishing an Inclusive Rate Plan

In setting up any system of hospital charges an attempt is made to establish a total revenue figure which approximates total cost. In establishing an inclusive rate, calculations will be based on the total return expected or required to meet the total cost of providing full service. Normal good budgeting principles should prevail with emphasis on past experience, the rate being adjusted to meet changes which good judgment may anticipate for the reasonably immediate future.

Establishing an inclusive rate on the straight line method is a simple procedure, particularly when excluded services are few. The operating position of the hospital must be analysed with all items of expense and supplementary income taken into account. This must then be apportioned over the various types of accommodation on a predetermined basis with the average daily income necessary then calculated in order to cover all expense.

Public Relations

One of the most important considerations involved in establishing a method of charging for hospital care is the effect on the patient-hospital relationship. Under the current system of charging — day rate plus special services — it is difficult for the physician or the hospital to estimate within a reasonable degree of error what a given patient's total bill may be for a given length of stay. This uncertainty is aggravated further by the abnormal physical and emotional state of the patient and his family. It is believed that under an inclusive rate system the psychological barrier of indefinite charges is largely removed and the patient's goodwill to the hospital and physician thereby strengthened.

Hospital charges in total — in relation to value received — definitely are not excessive; but when

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Blue Cross as a Social Force

James H. Stuart,
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THERE are many trends in hospitals which may be as obvious in Canada as in the United States. Hospital costs have doubled, tripled, and quadrupled in the past twenty years and will continue to go up. More and more hospital services now available will be ordered for each patient and more and more new services will be developed, used, and paid for. On each admission, more and more of the costly ancillary facilities provided by the hospital will be ordered by the doctor; in part because of diagnostic and therapeutic need; partly because of patient demand and, to some degree, because of the growing dependence of the doctor on tests and procedures, conveniently available in the hospital—for which payment will be made by a third party at little or no cost to the patient.

The incidence of hospital care per thousand of the population will continue to increase at an accelerated rate because more and more hospital beds for each thousand of the population will be provided to meet demands which may not be justified by need. It appears that with little or no scientific study, many communities are adding hospital beds not because of demonstrated need, but because of apparent demand. Without careful long-term community planning, such action may well be fatal to the voluntary hospital system and to voluntary prepayment. The cost of maintaining empty beds and unused hospital facilities may be overwhelming. But the cost of maintaining such facilities and having them used to capacity, when better care could be provided at much less cost elsewhere, could be catastrophic to the community, socially and economically.

A larger part of the hospital bill must be paid at the time care is given, and less operating income will come from sources other than patient care. Private philanthropy as a resource for meeting annual operating deficit is fast disappearing from hospital financing. Increased hospital income for patient care must come from third parties, since fewer and fewer patients expect or plan to pay for hospital care from current income or from savings. The American people have come to depend upon a Blue Cross Plan, an insurance company, or the government to pay their hospital bills. Which one of the three will eventually become the method of choice for financing hospital care will depend to a large degree upon actions of such groups as hospital associations plus a combination of other forces—social, economic, and political.

An address presented at the annual convention of the Maritime Hospital Association, 1956.

Origin of Blue Cross

The search for security which characterizes our generation includes security against the cost of illness. In one way or another our people will achieve security in this area. During the great depression an insistent demand arose from our people for a community mechanism through which hospital and medical care could be prepaid. From those who provide the services came a demand for some method whereby health care, rendered to self-supporting people of the community, could be paid for in advance of need.

The demand was not for *insurance* against part of the financial loss sustained by illness, but for a method by which hospital and medical care could be *prepaid*. The demand was not for a certain fixed number of dollars per day against the cost, but for prepayment of services when needed and in the amount necessary. The demand was not that certain segments of the community be covered at a rate proportionate to each segment's use, but that prepayment be made available to the whole community on a non-profit basis at a rate based upon the total community's usage. Here was a demand for a new instrument of social action with a new philosophy of community service through which all the members of the community might receive uniform treatment. Here was a recognition of the family and community social problem which sickness creates—a problem not solved by traditional insurance methods.

To the insurance industry, this new concept of providing service to people was not only unheard of and untried, but was unsound and financially impossible. The insurance industry declined to provide the mechanism required. To meet needs which were obvious, leaders in the field of hospital administration and civic leaders of the community undertook to fashion a new community service organization, a new instrument, to solve the economic problem of making the services of hospital available to the people and to help carry the community's social problem caused by illness.

Out of these local efforts an international movement, which we now call Blue Cross, was conceived and born. In due time another non-profit community service organization followed. The sister Blue Shield, was organized by the medical profession along somewhat similar lines.

The principles upon which Blue Cross was founded set it apart from other efforts to provide security against the cost of hospital care. Blue Cross was unique, distinct, totally unlike and in bold contrast to commercial indemnity insurance.

Because of misunderstanding of the basic philosophy of Blue Cross, because of efforts of the insurance companies to identify us with them, and because of our own failures to follow principles, there has been much confusion as to the difference between Blue Cross and traditional insurance programs. The two are not comparable. Their methods are different. Their purposes are not the same. Their functions, their traditions, and their history are not even related. They are different in operation, different in philosophy, different in purpose and objective.

Objectives of Blue Cross

Twenty years ago the three objectives of Blue Cross had already been developed. They were and still are:

1. The first objective was to provide an installment payment in advance method of financing hospital care.

Our cars, televisions, radios,

furniture, even our vacation trips are now purchased on an installment plan with payments after delivery of the article or after the service has been performed. For obvious reasons this type of installment purchase has not been applied generally to hospital and medical care, although it is not unknown in these services.

2. The second objective was to make hospital care available to the largest possible number of people at the lowest possible cost through prepayment.

The idea of a community program was foreign to insurance, and obviously Blue Cross could succeed in operating a sound community program of prepayment only if an adequate cross section of the community were quickly enrolled and remained enrolled.

3. The third objective was to help the community carry the social and economic burden which hospitalized illness has always created in every community.

Even at the dawn of civilization the community or the tribe assumed some casual responsibility for the care of its sick. From the time of Christ, it became an obligation of His followers to care for the sick and the poor. In our generation, the hospital has been forced to assume the responsibility for all the people, rich and poor alike, with new and extremely costly services demanded by the community for all its citizens. At the same time the community has demonstrated a willingness to pay for needed services given a workable method.

Basic Principles

To reach these objectives, five concepts evolved. These concepts developed into basic principles of Blue Cross Plan operation and became essential requirements for approval of the plan by hospitals.

1. The prepayment plan must meet the cost of essential hospital care for the member and make payment directly to the hospital for the services rendered.

This concept of service benefit—of paying the hospital for care given the member regardless of cost—was and still is the "corner stone" of the Blue Cross structure. This concept violated basic insurance principles and was in direct contrast to the commercial insurance concept of paying limited cash indemnity to the policy holder against his financial loss.

2. The people of the community must be given the opportunity to enroll.

Blue Cross rejected the established insurance principle of limiting coverage to persons with stable employment in selected groups, where low hospital usage and profitable underwriting could be expected. Equal benefits for all members of the family was an early requirement of Blue Cross operation. Full coverage for dependents had not been considered by the commercial insurance industry and to it the idea of underwriting a community risk was unthinkable.

3. Subscriber rates for each enrolled group should be based upon overall community experience.

From the viewpoint of the hospital and the community, the sick are people in need of hospital and medical care—not insurance risks. This care must be given in accordance with need, not in accordance with ability to pay.

4. Members must be permitted to continue in the plan regardless of changes in employment, age or deteriorating health.

This concept also looked toward meeting a community need, as well as helping to solve the financial problem of the hospital and the patient. This idea of continuous coverage regardless of changing conditions of health, employment, and insurability was entirely unsound from the commercial insurance viewpoint.

5. The plan, like the hospitals, must operate as a non-profit service organization.

Sickness and injury represent personal tragedies, often catastrophic, which people who are motivated by religious and humanitarian impulses have always tried to alleviate. There would seem to be little room for profit in dealing with such human problems.

Upon these principles, the Blue Cross movement in America has been built—principles designed to help the depression-ridden hospitals keep their doors open to serve

Blue Cross Plans in Canada Incorporated

Newly appointed officers for the Canadian Council of Blue Cross Plans are (left to right): President, Chief Judge Nelles V. Buchanan, Edmonton, Alta.; Secretary-treasurer, Ruth Cook Wilson, Moncton, N.B.; and Vice-president, D. W. Ogilvie, Toronto Ont.

At its annual meeting in Toronto on November 26th, the Canadian Council of Blue Cross Plans officially became an incorporated organization under a Charter granted by the Lieutenant-Governor of the Province of Ontario. Representing all Blue Cross Plans in Canada, the Council plays an active role in providing hospital care protection for employees of "national" organizations throughout Canada.

The newly appointed officers and board of directors for the Council are representative of Blue Cross Plans across Canada and include: *President*: Chief Judge Nelles V. Buchanan, Edmonton, Alta.; *Vice-president and chief executive officer*: D. W. Ogilvie, Toronto, Ont.; *Secretary-treasurer*: Ruth Cook Wilson, Moncton, N.B.

Board of Directors: Ruth Cook Wilson; Chief Judge N. V. Buchanan; Darrell Laird, Winnipeg, Man.; J. A. Likely, Charlottetown, P.E.I.; F. D. MacCharles, Winnipeg, Man.; E. D. Millican, Montreal, P.Q.; J. A. Monaghan, Edmonton, Alta.; B. M. Ogilvie, Montreal, P.Q.; D. W. Ogilvie, Toronto, Ont.; and C. N. Weber, Kitchener, Ont.

the public—principles developed to make it possible for the individual to pay for needed hospital care in advance—principles implemented to help the community solve an increasingly costly social problem, which in a large measure has been a community responsibility since the dawn of the Christian era.

These principles in essence became basic requirements for sponsorship by local hospitals and for approval by the American Hospital Association. The actuarial safeguards of limited dollar liability—which often leaves a major part of the hospital bill unpaid; of protection for selected groups and individuals only — which obviously tends to deny protection to the people who need it most; of termination of coverage when employment or insurability changes — which tends to deny protection to people when they need it most; all these financial safeguards, common to commercial insurance operations, were not sought by Blue Cross.

The solution of the community's social problem and the hospital's economic problem could hardly be found in the traditional insurance company method of indemnification against loss, with concepts of limited liability and termination of coverage when employment changes or the risk deteriorates because of age or poor health.

These problems obviously could not be solved through the utilization of these standard insurance principles. But a community prepayment program could no more afford to exclude people because they are "poor risks", than a voluntary hospital could afford to exclude patients because they are "poor pay". If the problems involved could have been solved through insurance, there would have been no need for the hospitals to organize and guarantee Blue Cross as a prepayment plan of their own. In return for providing service benefits, assuming community risks, and continuing coverage regardless of work, age, or health conditions, Blue Cross had to be given a preferred position. This preferred status, which Blue Cross was given by the hospital—its sponsor and creator—has long been questioned by our commercial imitators, who spurned the opportunity to provide the needed programs of protection and who even now offer coverage which at best is temporary and partial.

Health care in an expanding economy is not easily translatable in terms of dollars of indemnity, nor purchasable in convenient frozen segments, good only as long as current underwriting conditions remain. Any cash indemnity program sufficient to meet the average needs in one area, may well be inflationary in another and grossly inadequate elsewhere. The cost of hospital care can never be the same everywhere, nor can dollars be matched evenly anywhere against services needed. If the individual could be assured that he would have an average illness, at an average cost with an average length of stay, then he might buy adequate protection in uniformly packaged dollars of indemnity.

The insurance companies, of course, assume no responsibility for solving the financial problems of the hospitals, of the community, or of individuals, except within the dollar limitations of the policy. The entire community is not given an opportunity to enroll; rather, the best groups from a risk standpoint are selected and the premium rates are based upon the experience of the group covered.

Traditional insurance makes no pretense of meeting the needs of the community, nor of meeting the needs of the hospitals. Reputable companies do exactly what they say they will do. They indemnify. During the coverage period, they provide cash against the cost of illness for those who buy their protection.

According to Need

But the social problems of making available the services of the hospital and the medical profession to all the people, of meeting the community's problems in the area of security against the cost of illness and of making it possible for those who provide health services to continue their work with the assurance of being paid for services rendered, cannot be met, and will never be met through the traditional insurance method.

If the voluntary hospitals carried no responsibility for service to people unable to pay, the hospital's financial needs might be met through such insurance programs; but unfortunately hospitals must provide care to people according to their need, not

Comprehensive Plan for Railway Employees

As of January 1st, 1957, approximately 130,000 non-operating Canadian railroad employees participate in a comprehensive health-welfare program. This group will include employees of Canadian National Railways; Canadian Pacific Railway Company; Toronto, Hamilton and Buffalo Railway; Ontario Northland Railway; and Algoma Central and Hudson Bay Railroad.

An important feature of the program, from an employee standpoint, is the provision of hospital and surgical-medical care protection, with Blue Cross, Trans-Canada Medical Plans, and Associated Medical Service of Ontario as the carriers. Owing to the existence of government-sponsored plans in several Canadian provinces, many problems were presented because all railroad workers are required, under negotiated agreement, to pay equal amounts regardless of residence. Since railroad employees in Saskatchewan and British Columbia are already covered under compulsory arrangement for standard ward hospital care, it was necessary to provide them with an additional scale of benefits. To meet this problem, a "semi-national" approach was conceived, and benefits provided under the agreement for employees west of Manitoba will be different to those east of Saskatchewan. In the provinces east of Saskatchewan, the employee will receive basic standard ward hospital, surgical-medical "in-hospital" benefits. In the western provinces a wider range of surgical-medical coverage is provided which includes doctors' services in the home and office as well as in the hospital. The railroad company concerned and workers equally share the cost. Recognizing that many workers may wish a higher scale of benefits than those provided under the company plan, arrangements have been made so that these employees may authorize an additional payroll deduction in order to purchase a higher level of benefits, *e.g.*, semi-private hospital accommodation and home and office calls. Arrangements were also made to provide railway pensioners with protection in accordance with need and ability to pay.

according to their insurance or bank account.

Insurance companies were and are in the business to make money, not to finance hospitals, not to solve community problems. There is nothing wrong with making money, but the non-profit hospitals may well question whether or not money should be made through the provision of their services to the public.

In meeting the need for prepaying hospital care, the Blue Cross principles—service benefits, enrollment for everyone, continuation of coverage regardless of changes of employment or health condition, non-profit operation and community rates—are all as sound today as they were twenty years ago. In no other way can the need be met through voluntary action.

The Blue Cross objectives—to provide comprehensive protection against cost of hospitalized illness to as many people as possible at the smallest cost possible, to provide a broad base for financing the voluntary hospital system through prepayment and to help solve the community's social and economic problems which illness creates—are even more important today than they were twenty years ago. The stakes are higher—costs have doubled and tripled and still must go up. With each upward movement, the public's need for protection increases and the problem of financing hospitals grows.

These objectives cannot be attained through any program which provides temporary or partial protection or even full protection to groups or individuals who will likely need to use the hospital least. Any prepayment plan — Blue Cross or otherwise — where such ideas prevail cannot meet the demands and needs. Hospitals cannot be financed from patient income from people who do not become patients. Hospitals cannot select their patients or limit their responsibility to special economic groups. They must give care to all and they must be paid for this care when rendered.

Plans which provide benefits to people during employment, or during good health, are of limited value; and from every point of view it would seem difficult, if not impossible, to solve the problem of prepaying for hospital care through those programs which are motivated by profit.

Can Blue Cross Meet the Need?

Is Blue Cross meeting the needs in solving the problems of the individual, the community and the hospitals? Can it meet these needs? The answer is "Yes" in some areas—but only partially so in others.

One-third of the population of the United States now has Blue Cross; but population coverage varies from state to state and from plan to plan. In 25 plan areas in the United States from one-half to four-fifths of the total population is covered. In other plan areas it is as low as 8 or 10 per cent. In plans where a high percentage of the total population is covered, the following factors are constant:

1. The level of service benefits is high and reasonably comprehensive in nature. The plans now growing most rapidly are the plans with the comprehensive service contracts.

2. The plan has not substantially deviated from basic principles and philosophy of community action.

3. Blue Cross is identified as the hospitals' own prepayment plan and the relationship between the hospital and plan is that of full partnership.

4. Blue Cross is recognized as the program of choice by the hospitals and the community and not identified as another insurance operation.

5. Relationships with hospitals, medical profession and the subscribers are organized and broadly based on community councils and committees, in addition to board representation. The Blue Cross communities of interest are organized to promote and protect the plan. The lines of communication and liaison are securely formalized.

The organization is not exactly alike in any two cases. But in every case the original objectives and basic principles are still kept in mind and followed. Variations which have come about through the stress and strains of competitive living are largely procedural and not substantive in nature.

Wherever a Blue Cross Plan in the United States has permitted itself through lack of understanding, through expediency or fear to become identified as one of many insurance operations, its rate of growth has declined and in some areas ceased. Where the community's social needs were forgotten or exchanged for techniques and gimmicks of the in-

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National Blue Cross Association

A major change in the structure of Blue Cross national hospital prepayment activities has been announced by Robert T. Evans, Chicago, Chairman of the Blue Cross Commission of the American Hospital Association. Revision of the Blue Cross Association, an Illinois corporation chartered in 1948, to encompass national enrollment programs of Blue Cross is the primary step in the change. Dr. Basil C. MacLean, New York City's Commissioner of Hospitals, has resigned his post to accept the presidency of the Blue Cross Association effective February 4, 1957. Before now, the Blue Cross Association was an instrument of the Blue Cross movement with limited responsibilities. Health Service, Incorporated, a health insurance company wholly controlled by Blue Cross Plans was one of the first responsibilities of the Association after it was established. Health Service Incorporated, will continue to be a national underwriting vehicle for Blue Cross Plans under the new arrangement. Mr. Evans pointed out that the Blue Cross Commission would continue, as a part of the American Hospital Association, to serve as the national co-ordinating agency for the Blue Cross Plans of the United States and Canada. The Commission will retain activities which are concerned with management problems of Plans while the Association will deal primarily with sales and member-directed functions.

Dr. MacLean, one of the original founders of the Blue Cross movement nationally, brings to his new post a distinguished record of hospital administration, public health administration, and wide knowledge of health economics problems.

There are now over 52 million persons enrolled in Blue Cross Plans. It is estimated that the Plans will have paid over a billion dollars to hospitals during the past year for care rendered these members.

Let's Look at Education

Ronald J. McQueen

THE busy hospital executive officer has a working day which usually extends into the evening and week-ends; there seems to be no end to the matters which have to be handled—no finish to the projects which the keen-minded person believes should be undertaken. How can you ask the administrator or assistant administrator, working under pressure, to undertake an educational program for his or her improvement? Where will the time be found to read lessons, write assignments, and attend summer sessions? The facts speak for themselves. This summer brought the certificate of graduation in the Canadian Hospital Association's (extension) course in hospital organization and management to 58 of these busy people, making a total of 160 persons in Canada and 8 in other countries to complete the course. Somehow they found the time to fulfil the requirements of the program while occupying a responsible position in a hospital. There are 69 members enrolled in the second year of the course and 83 are well under way with the first-year lessons.

A look at the charts, which show several analyses of the classes in this two-year program, will indicate the geographical areas where a better representation would be desirable. The course has proved beneficial to those in all sizes of hospital; although it is recognized that detailed study of departmentalization may not be of so much value to the administrator of a 30-bed hospital as to the one in a 200-bed institution, the principles of administration are equally applicable.

The analysis of first-year admissions reveals the variety of backgrounds from which students are drawn for this course. It also brings credit to the individuals, committees, and executives of national associations who were able to prepare a course with such finesse that it appealed equally well, and with interest, to individuals having highly-advanced or specialized education as to those who were unable to obtain a lengthy formal education.

During the months from September to April of 1955-56, a group of 24 markers across Canada evaluates the 1,769 assignments submitted in this extension course; these are busy persons in very responsible positions in hospitals and universities who contribute many long hours of work in the hope that their comments will be of value to the students. The high quality of work submitted by those enrolled is indicative of the seriousness with which study is undertaken. The assignment questions vary in type from theory, as outlined in the lesson and required reading, to an analysis of specific procedures in the student's hospital. Both are valuable and aid in developing one's understanding of the theoretical approach and the practical application of it.

The four-week summer session of the extension course in hospital organization and management was held at Huron College, in London, Ontario, on the campus of the University of Western Ontario, during the month of June. A very full program of lectures, discussion groups, seminars, problem clinics, and field visits kept the 124 students extremely busy. This is not a holiday, as anyone who has attended will testify. Lectures attempt to amplify the winter lessons, and include subjects which it is considered better to teach by this method. There is ample opportunity for discussing the content of the lessons and the subjects which are presented for the first time. Individual student participation, by project, presentation, and general discussion, is expected.

This course has had almost unqualified success since its inauguration in 1951. The idea was developed by officers of the Canadian Hospital Association, and has had the active co-operation of countless persons in this country as well as the Department of Hospital Administration of the University of Toronto. The financial support of the W. K. Kellogg Foundation has made it possible. It is difficult to gauge accurately the benefits derived from such a

Extension Course in Hospital Organization and Management

Geographical Classification 1956-57	Graduates to Date	Students 2nd Year	Students 1st Year
British Columbia	26	8	8
Alberta	10	6	9
Saskatchewan	10	8	8
Manitoba	17	1	2
Ontario	68	27	32
Quebec	14	4	7
New Brunswick	1	5	3
Nova Scotia	7	3	3
Prince Edward Island	3	1	—
Newfoundland	4	3	4
Yukon	—	1	—
U.S.A.	6	2	7
Overseas	2	—	—
	168	69	83

Total number of students in 1956 classes: 152.

Size of Hospital	Students 2nd Year	Students 1st Year	Totals	Percentage of Total
50 and under	10	15	25	16.4
51-100	11	13	24	15.8
101-200	17	15	32	21.0
201-500	16	20	36	23.7
Over 500	6	12	18	11.9
Not in hospitals	9	8	17	11.2
			152	100.0

Extension Course in Hospital Organization and Management

Analysis of First-Year Admissions

Classification:	1951	1952	1953	1954	1955	1956
Total Students	47	59	61	80	82	83
Federal Government:						
Department of Veterans Affairs	4	3	5	4	4	4
Department of National Defence	1	2	1	6	5	5
Department of National Health and Welfare	—	3	2	1	3	2
Provincial Government	1	2	1	6	2	5
General Hospitals	38	42	41	55	61	56
Sanatoria and other Special Hospitals*	3	4	11	6	4	10
Other	—	3	—	2	3	1
Nurses	10	6	14	11	17	18
Doctors	2	9	4	4	3	6
Administrators	22	15	15	16	18	24
Assistant Administrators	5	3	5	14	14	14
Department Heads	3	8	13	12	14	6
Secretary-Treasurers and Secretary-Managers	8	6	7	6	10	2
Business Managers and Office Managers	3	7	10	9	10	10
Accountants	2	5	5	11	6	8
Sisters:	10	6	9	10	18	14
Nurses	4	2	7	4	11	12
Administrators	5	3	4	5	5	7
Assistant Administrators	1	2	1	1	5	2
Other	4	1	4	4	8	5
Male	30	45	45	59	55	64
Female	17	14	16	21	27	19
Age Groups:						
Under 31	—	11	11	15	10	14
31-35	6	8	12	12	12	18
36-40	16	18	18	19	19	17
41-45	16	13	14	18	26	18
46-50	8	4	4	8	9	12
Over 50	1	5	2	8	6	4
Academic Status:						
Below Junior Matriculation	8	10	9	13	10	11
Junior Matriculation	15	12	17	23	30	24
Senior Matriculation	17	22	14	17	26	23
Partial University	—	—	4	7	2	2
University Degree	7	15	17	20	14	23
Academic Standing improved by Special Courses	—	—	39	45	53	45

*Cancer, psychiatric, convalescent, industrial, leprosarium and homes for the aged.

program. The interest of the students, the continuing interest of the graduates, and their success in the field are ample rewards for those who germinated the idea and fostered it to reality. The interest of individuals, universities, and associations in other countries has also been gratifying. The aim is to improve the standard of hospitalization in Canada by presenting a program for those senior executives in hospitals who have not and will not be able to undertake a formal postgraduate program in hospital administration; as such it has already made a significant contribution. If applicants of the desired quality continue to request enrolment in the course in sufficient numbers to make it possible to operate, this program will continue to provide whatever measure of aid it can to fulfil its purpose.

For Medical Record Librarians

In the continuing effort to improve the standard of our hospitals and provide a better quality of care for the patient, one of the essential persons has been the trained medical record librarian. It is under her guidance that the completed medical records should be maintained and analyzed for useful purposes. The shortage of such experts is well known to every hospital administrator in Canada and the United States. In 1953 the Canadian Hospital Association and the Canadian Association of Medical Record Librarians presented an extension course to train medical record librarians and thus help relieve this problem. In 1956 the second class of the 2-year program was graduated, with 29 members; there are now 58 such graduates, a beginning on the major task of building and keeping a supply of such personnel—as a supplement to the hospital schools where formal courses exist for this purpose. It is hoped that the 30 students in the second years of the course and the 48 in the first year will make a significant increase in the total of this specialty group.

This course may be taken as an introductory year, complete in itself, or with a further year which amplifies the first-year program; very few students are satisfied with one year only, and those who complete it satisfactorily almost invariably complete the entire program. Assignments during the winter term are submitted, evaluated, and returned with comments to the students. A loyal core of senior medical record librarians across the country marked 964 of these assignments during the 1955-56 term, an im-

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Notre-Dame Hospital in Montreal Initiates

Nursing Research

Sr. Mance Décary, s.g.m.,
B.Sc., M.B.E.,
Director of Nursing,
Notre Dame Hospital, Montreal.

IN a hospital, the work of all departments is focussed on the patient through the nursing department. It is the crossroads of the various administrative departments, hence the great importance of its role and the necessity for its efficiency.

As early as 1951, feeling an urgent need for better integration of nursing activities, we undertook an analysis of sterilization techniques which brought about appreciable change. However, considering the current enlargement of our hospital and the complexity of services, a job study carried out according to the rigorous methods of scientific research proved necessary for all categories of nursing personnel.

Such an extensive undertaking could not be achieved without the co-operation of the hospital authorities. We therefore outlined our plan to the General Director who, well understanding its importance, presented the project to the Board of Administration who readily gave unanimous approval.

The launching of this project was made possible through the co-operation of Department of Health, Province of Quebec and of the Department of National Health and Welfare in Ottawa. Consequently, during the weeks beginning August 27 and September 3, 1956, the entire nursing personnel took part in the research work. The activities of the head nurse were recorded, watch in hand, and so were those of the assistant head nurse, the graduate nurse, the student nurse, the nursing auxiliary, the nursing aid, the orderly and the receptionist. It was the first time in Canada that a study had been undertaken on that scale. This extensive experiment requires some explanation.

Having been assured of an adequate budget, we planned our program. Three members of our nursing staff were sent to study team work at Teacher's College, Columbia University, New York, in order that they might efficiently guide us in our work of re-organization. In addition, we requested the assistance of the Research and Statistics Division of the Department of National Health and Welfare which is directed by Dr. Joseph W. Willard. Gordon H. Josie, supervisor of the Biostatics Section and Charles B. Walker of the same department came from Ottawa to see for themselves the working conditions peculiar to our hospital before planning a schedule which would suit our situation. A preliminary step was the training of observers. We selected them from the personnel of our hospital as they all had to serve as guides in the re-organization program. We also secured the assistance of a member of the Marguerite d'Youville Institute, an expert in education.

The plan of investigation may be summarized as follows: observation periods, personnel to be observed, guidance of observers, recording techniques, coding, analysis, evaluation of data collected. In addition, the observers had to familiarize themselves with all the printed forms in use in our hospital, to know their utilization in order to determine the time required to complete them.

The staff was informed of this great undertaking by means of a questionnaire composed of 297 questions which was sent to the physicians and to the entire nursing staff. It was entitled: "Study

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The director of the study tells her observers the day's schedule. From left to right: Sr. J. Forest, E. Bernier, Sr. Mance Décary, research director, Sr. A. Rose, J. Ouimet and P. Roy. Above article appeared originally in French. See November, page 58.

Annual Convention of

C.A.M.R.L.

Doris McPherson

THE 22nd annual convention of the Canadian Association of Medical Record Librarians was held October 10, 11 and 12 at the Hotel Vancouver and St. Vincent's Hospital, Vancouver, B.C. On the evening preceding the opening sessions, an acquaintance tea was held in the nurses' lounge of St. Paul's Hospital.

The meeting opened with the president, Mrs. Ruth Melby, in the chair. Official greetings were extended by Mrs. A. Sprott, an alderman of Vancouver, and by Dr. B. Lamonte, a director of the British Columbia Medical Association. Mrs. Melby then expressed a sincere welcome to all members. The first speaker on the program, Dr. J. A. MacDougall representing the B.C. Hospitals Association, presented a most informative and thought-provoking discussion on "Our Challenge of Twenty-five Hundred Years". A luncheon was held in the Hotel Vancouver; the guest speaker, Miss Marie Moreau, fashion editor of the Vancouver Sun, gave some excellent advice on good grooming and clothes purchasing.

In the afternoon Mrs. Mildred Smith of the Vancouver General Hospital presided, while Dr. Lawrence E. Ranta, assistant director, medical, Vancouver General Hospital, spoke on the "Control of Patient Care". Dr. Ranta pointed out some important factors which must be taken into consideration in order that the best care possible be attained for the patient. He mentioned the responsibilities of the board of trustees of a hospital to itself, its hospitals and its patients in appointing a medical staff which is sound in ethics, training and judgment, in the establishment of rules and regulations to which the medical staff must adhere, and in the formation of committees whose function is to determine if the care of the patient has met proper standards.

Sister Mary Catherine, St. Joseph's Hospital, Victoria, B.C. was chairman of a morning session, which was held at St. Vincent's Hospital. Dr. Stewart Murray senior medical officer, Department of Public Health, Vancouver, gave an explanation of "Public Health Resources and Why". Dr. Murray outlined the factors which influence the state of community health. The speaker made an interesting point when he stated that longevity should not be an end in itself but rather effective living for the older person.

A panel discussion was entitled: "Medical Record Librarians. Are We Taking our Place in the Professional World?" Dr. Margaret McGuire, director, School for Medical Record Librarians, Winnipeg General Hospital, Winnipeg, Man. was moderator of the discussion. L. F. C. Kirby, director, Royal Columbian Hospital, New Westminster, B.C., J. Kinnard, an administrative analyst in the personnel placement field, Monica Shand and Laura Larkin, medical record librarians at the Burnaby General Hospital, Vancouver, and Sunnybrook Hospital, Toronto, respectively, were the panel participants. Opinions expressed by the individual speakers brought forth lively discussion from the audience.

In the afternoon, a tour of one of three hospitals was available. Terminal digit filing and machine tabulating were demonstrated at the Vancouver General Hospital; microfilming and the outpatient department were the features at St. Paul's Hospital; at the Royal Columbian Hospital, the imprint-plate system used in the admitting department and the school for medical record librarians were observed. The British Columbia Association of Medical Record Librarians was host at a social hour in the Auxiliary Lounge of the B.C. Cancer Institute. Subsequently, a buffet supper was enjoyed in the recently remodelled cafeteria of the Vancouver General Hospital.

Dr. A. J. Nelson, Assistant Dean, Faculty of Medicine, University of British Columbia, was the first speaker at a morning session which was presided over by Mrs. Grace Cockrem, Grace Hospital, Winnipeg. Dr. Nelson gave a very comprehensive picture of man and his relationship to disease—the causation, and the methods by which it may be attacked, controlled and prevented. The second speaker, Professor Earl D. MacPhee, Dean of the Faculty of Commerce and Business Administration, University of British Columbia, discussed "Executive Behaviour". Professor MacPhee concentrated on one basic premise—that, on the assumption that one is in charge of an office or department, he or she should strive to be a manager and not a "boss" and that the ability to manage should not be measured by technical competency.

With Mrs. Ruth Melby as chairman, Dr. L. E. Ranta was chief justice at a court scene where the audience was "Medical Record Librarians on Trial". Questions appropriate to medical record librarian work requiring true or false answers were posed to the audience. Individuals were selected by the roving lawyer for the defence, H. P. McLaughlin, assistant director, Vancouver General Hospital, to answer questions asked by the crown prosecutor, L. Wilson, of the same hospital. The chief justice and his assistant, Doris McPherson, gave judgment on the answers. This was a very amusing as well as thought-provoking session.

A business meeting then followed. Reports of the committees on finance, membership, bulletin and nominations were read and adopted. Reports by the registrar, the board of registration and the supervisor of the extension course for training medical record librarians were likewise read and adopted. It was decided that a central office for the conduct of association business should be established as soon as possible and that the meeting of the association should be held biennially. Other business being completed, Mrs. Melby closed the meeting with a short resume of her impressions and thoughts concerning the Second International Congress on Medical Records, Washington, D.C.

An installation banquet was held at the Faculty Club of the University of B.C. A life membership was presented to Laura Larkin, Sunnybrook Hospital, Toronto, in recognition of her work as a founding member of the C.A.M.R.L. Seven other life memberships are being presented to the other founding members and Miss Larkin accepted on their behalf. Margaret Heenan, St. Joseph's Hospital, Saint John,

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How to Join the C.A.M.R.L.

Virginia D. Stannard
Vancouver, B.C.

THE questions "What do I have to have to join the Canadian Association of Medical Record Librarians?" and "Do I have to be a registered record librarian in order to join the C.A.M.R.L.?" and comments such as "I've just discovered I do not have to be registered to join your association" reveal an apparent need for making the requirements for membership in this association known to many interested persons outside the group.

Anyone interested in the objects of this association may apply for membership. Interest is the minimum requirement for membership. Interest and an application fee of two dollars.

If these, and the annual dues, are all an applicant has to offer as her initial contribution to the association, she will be a welcome member. She will be assigned to the class of membership that her position, or present and past positions indicate, and will enjoy the privileges that her particular clasification of membership offers. These vary according to membership, but all members are entitled to receive a copy of each issue of the *Bulletin*, the bi-monthly publication of the association, free of charge.

Any class of membership entitles a member to the advantages of belonging to a group dedicated to furthering the work in the field of medical records, a group with high ideals, one in which problems are shared, experiences exchanged, where opportunities exist to ever increase one's knowledge, to join in the teamwork, and to make a worthwhile contribution to the community, clinic, hospital, research laboratory, or public health program.

Question: What must be done to join the association?

Answer: Write to the chairman of the membership committee and request that she send to you an application for membership form. (Send no money.)

When the forms (2) have been completely filled in, return them to her with the application fee. (Do not send in annual dues at this time.)

The membership chairman will advise you when your application has been accepted and inform you regarding your class of membership and the amount of your dues and method of payment. A copy of the constitution and by-laws of the association will be enclosed for your keeping and perusal.

There are several classes of membership in the C.A.M.R.L. — active, members-at-large, junior, associate, and honorary. Your assignment to one of these classes will be determined by your position—whether or not you are a chief M.R.L., assistant M.R.L, and how long you have been in your position, or positions, if you are a graduate of an approved school for the training of M.R.L.'s, or merely interested in the objects of this association and one who is

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Modern Medical Record Department

Pictured here is the medical record department of the Edmonton General Hospital, Edmonton, Alta. Sister M. P. Rheault, R.R.L., the librarian in charge, is also director of the school for medical record librarians (approved in 1955 by the Canadian Association of Medical Record Librarians). The students of this school have most of their practical experience in this setting. A number of students taking the Canadian Hospital Association extension course for training medical record librarians have also been fortunate in being able to take an intramural session in this bright and well-equipped department.

You Were Asking . . .

Several administrators were invited to answer the following question: *"Should it be hospital policy to lend equipment for use outside the hospital by (a) discharged patients (b) patients attending as out-patients (c) patients of members of the medical staff who have not been in-patients?"* The answers received are as follows—*Edit.*

THE answer will depend on the size and location of the hospital. We are all aware that conditions differ in rural and in urban areas. In the large hospital in the city, one has recourse to many agencies. In our small town, with its hospital of some seventy beds serving wide rural areas, our policy has been as follows:

(a) Discharged patients. First of all one must take the particular circumstances into consideration. At present we have one of the local drug stores providing certain items of hospital equipment on loan. This has greatly lessened our load. Public relations is a very important measure in small localities and a service such as this is very helpful.

(b) Out-patients. Splints, et cetera, are charged to the patient for the time of use. (c) Here again we have a situation involving public relations and co-operation. If the local drug store or other agency cannot provide the equipment, it is a courtesy to the member of the medical staff and also a means of proving our status as part of the community.—*Sister MacKenzie, Hotel Dieu of St. Joseph, Chatham, N.B.*

THE question will be subject to different answers in different localities. In our own comparatively isolated, rural, island community it is hospital policy to lend equipment, *i.e.*, hospital beds, orthopaedic walkers, crutches, and splints in some cases. It is not our policy to lend anything which would normally be available from a local retail or wholesale outlet, except in an emergency and until such time as the patient could procure that item.

Our answer to (a) and to (b) is "yes". The number of loans in a year would be negligible. In the case of (c) the answer is "no". Theoretically, a hospital should not become involved in loaning equipment; and wherever possible should refer such requests to local Red Cross or other community welfare agencies. This would be my answer: in theory it should be avoided; in practice it may be necessary to contribute to the rehabilitation of the patient and it is our responsibility to serve the sick and injured both within and outside the institution.— *John E. Ledgerwood, Prince County Hospital, Summerside, P.E.I.*

I THINK it should be hospital policy to rent emergency equipment to any patient in either of the three groups. A nominal deposit should be required to assure its return. Emergency equipment such as crutches, splints, fracture boards, et cetera, could be available on the above basis through the out-patient department.

In larger centres equipment is available on a rental basis through hospital supply companies and the Canadian Red Cross. Care should be taken to avoid competition with these companies. In smaller centres this equipment should be available through the local hospital.—*Brig. Gladys W. Gage, Grace Hospital, Winnipeg, Man.*

BEST patient care at the lowest possible cost means, among other things, having the required amount of equipment available for the task at hand. If material has been loaned outside of the hospital it is not available inside, unless there was more than necessary in the first place. This is a negative answer to all three parts of the question. The problem is how to make and enforce the rule.

First, obtain the authority of the board. Next issue strict orders that, in future, all hospital equipment (such obvious things as crutches, walking irons, canes and other special out-patient equipment being excepted) is not to be loaned to doctors, staff, or discharged patients or anyone outside of the hospital. Explain to all that a public hospital is a community property, provided by the citizens for their welfare and that it cannot do the job properly if it must conduct an equipment-lending business on the side. If it tries, it means catering to the wrong types, the borrowers, and those who like to get things the easy way. It means both clerical work in recording the location of the borrowed equipment and the effort to retrieve it, as well as either the expense of duplicating equipment in the meantime or not having it when it is needed in the hospital. The latter reduces the efficiency of the hospital.

Go to the trouble of finding a source of supply, or even if necessary, arranging one and inform all concerned where such equipment can be hired. Remember, and tell the medical staff diplomatically, that the hospital is not a supply house. However, in a real emergency you must be human.

Equipment borrowing, like any type of borrowing, starts on a small scale and grows quickly both in the number and size of the objects. Stopping it leads to better housekeeping, and better patient care. I believe this—I have tried it, it works.—*A. S. L. Corner, Lachine General Hospital, P.Q.*

IN reply to (a) we loan crutches, wheel chairs, gatch frame beds, et cetera. Our policy is to charge the individual with the full price of the equipment when it leaves the hospital, and when it is returned we charge a nominal fee as rental, rebating the original charge.

(b) We loan crutches and canes to patients attending the hospital as out-patients. In this instance we charge the patient the full value of the cane or crutches and refund the money when they are returned, less a nominal fee for the use.

(c) It is not our policy to loan equipment to this group.—*D. R. Easton, M.D., Royal Alexandra Hospital, Edmonton.*

PROPER maintenance of hospital equipment results in economy. In my opinion there is no better way of jeopardizing it, than by adding the "lend-lease" bill to the policies of the hospital. It is true that a hospital with the right to function also has the duty to assist a patient in need—for example the home-bound, home-bed-patient with a physical handicap. To refuse such a patient a piece of equipment on the basis of policy,

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For Trustees Only

Industrial Relations — their impact on hospitals

Alexander Harris,
Chairman, Board of Trustees, Kirkland Lake and District Hospital, Kirkland Lake, Ont.

PERHAPS the most important trend in industrial relations during the past decade has been the steady reduction of the work-week in industry, with the adjustment of wage rates to compensate employees for the shorter number of hours worked. This is usually referred to as "maintenance of take-home pay" but this is a misnomer because it does not necessarily do this, that is, maintain take-home pay. Take-home pay, so-called, often includes a number of variables such as incentive plans, and consideration of deductibles such as income tax. We have seen the reduction in work-week from 48 to 40 hours and, in some cases, to less than 40 hours. There is evidence in industry generally of a trend to a work-week of less than 40 hours. It had been intimated by unions that there would be increased efficiency brought about by the shorter hours per week and that this would result in no over-all increase in costs. However, actual experience has shown that costs have risen because more employees were needed to accomplish the same amount of work in the shorter work-week.

Coupled with the conversion of wage rates to compensate for the reduced work-week, and subsequent to these adjustments, there has been a stepped-up series of wage increases. This may be considered the second important trend. Whereas, at one time, a wage increase of 5c or 10c per hour across the board was considered a satisfactory settlement of wage demands, nowadays so-called "package" settlements above these figures are commonplace. The "package" may include a fairly substantial wage increase plus "fringe" benefits such as employee welfare plan payments. An indication of the extent of increases in wage rates in manufacturing industries during the last seven years, is the Dominion Bureau of Statistics Index figure of 150, representing the May, 1956, average weekly earnings in industry, as compared with the index of 100, the comparative index for the monthly average during the year 1949. In other words, weekly average earnings in industry rose 50 per cent between 1949 and May, 1956.

An address to the 32nd Annual Convention of the Ontario Hospital Association, Toronto, Ont., October, 1956.

Guaranteed Annual Wage

Another trend which has been given a great deal of publicity is towards the guaranteed annual wage which is, in reality, a supplementary unemployment insurance scheme. This was first initiated on a big scale in the automobile manufacturing industry where, in the past, there was a need to stabilize employment. There was a need to level off the peaks and valleys of employment in this industry. The guaranteed annual wage has been accepted in other industries and there are, of course, many industries where the equivalent of a guaranteed annual wage has been in existence for many years. In fact, one may say there has been a better arrangement than is provided by the G.A.W. In such industries, there has been steady, all-year employment with no lay-offs. Our public hospitals fall into this group.

The extension of so-called "fringe" benefits has been a decided trend in the past number of years. As one observer has put it, the "fringes" have grown "tassels". These "fringe" benefits include statutory holidays, vacations with pay, and employee welfare plans of various kinds paid for wholly or in part by the employer. These payments, while not reflected in the actual wage rate or actual earnings per week, represent, in a good many cases, as much as 25 cents per man-hour. These payments mean a substantial saving to the employees affected and an increased burden on industry.

In the last few years, there has been a trend towards longer term agreements. Whereas at one time, union agreements for a longer term than one year were the exception, there are many agreements being entered into today for terms of two years and longer. It is hoped this will have the effect of stabilizing relationships by avoiding the uncertainties involved in annual negotiations. In order to obtain the long-term agreements, industry has had to offer special inducements in the way of wage increases and other benefits. Perhaps industry has looked into the crystal ball and ascertained that there will be a continued upwards surge in our industrial development.

What has been the effect of these trends? And what will be the effect in the future? There can be no quarrel with the increased earnings and other benefits of those employed in industry, and that embraces most of us, as long as our general economy remains unimpaired. There can also be no quarrel with the conclusion that the costs of manufacturing practically every commodity have gone up as a result of wage increases and the increased costs of raw materials, again partially due to increased costs of production. That is the answer to the first question I have raised. What the effect, in the future, of this spiral of constantly rising wage scale and costs of consumer goods will be, is anyone's guess. Some people, in high places, maintain that the spiral is a good thing and that it will never end. Some economists are equally optimistic but others take rather a gloomy view.

I raise these questions because of the effect the spiral has had on hospitals and the effect it will likely have in the future. There has been a steady rise in costs over which hospitals have no control. Those costs under control of hospitals have been maintained as well as circumstances permit. The uncontrollable costs, those brought about by increased cost of supplies and equipment, coupled with the limits within which we may raise hospital fees, have the pub-

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For the Aging—

Emphasis on Protein Requirements

Elizabeth H. MacMillan,
Dean of Home Economics,
Acadia University,
Wolfville, N.S.

DURING the past twenty years or so, much work has been done in the field of geriatrics and gerontology, the care of the aged, and the science of aging or the aging process.

The time in the life of an individual when the process of aging commences is not sharply defined. Stieglitz[1] states that in many respects the two decades from forty to sixty are the most significant, for in these years of later maturity the future health of the aged is determined. He finds it practical to assume that geriatric medicine becomes applicable at approximately forty years of age, for it is at this age that the progressive disorders, so significant in later years, first become manifest.

Keys[2] points out that physiological age cannot be predicted from age in years alone. The age at which an individual has definitely reached a decline in physical vigour may start at forty years or it may be postponed to seventy years or more; commonly it is reached in the sixties.

It would appear that no one has yet been able to define problems of aging in a manner acceptable to everyone. Shock[3] says he would regard as age changes, all alterations in function that show a progressive change with age, in subjects where the best diagnostic devices fail to demonstrate the presence of clinically identifiable disease. There are some who believe that aging is a pathological process or that the length of life of an animal is limited only by the accumulation of pathology and disease.

There is another school of thought that looks upon aging as a biological process inherent in all animals, which proceeds even in the absence of disease.

Shock[3] states that the ultimate goal of research on aging is an understanding of the mechanisms whereby cells lose their ability to maintain their existence.

The tissue cells are maintained through the internal environment and here nutrition plays an important role. Nutrition includes not only the ingestion of foods but also the digestion of foods, their absorption, transportation to tissue cells and utilization by the cells.

Stieglitz[1] points.. out that impaired cellular nutrition in the aged may result from inadequate nutritional supply, inefficient distribution, ineffective utilization of food elements, accumulation of injurious metabolic debris. Thus he states malnutrition may be endogenous as well as exogenous.

There seems to be quite general agreement as to factors that may promote exogenous malnutrition in the aged. Some of these are missing teeth, faulty dentures, and what McCay[4] calls the sociological and economical factors, *e.g.*, low income, poor facilities for food preparation, ignorance of nutritional values, mental deterioration, worry from insecurity, physical handicaps. While caloric undernutrition can and does occur in old people, it is possible that in America, the opposite form of malnutrition, obesity, is far more common and troublesome.

There is less evidence as to factors that may promote endogenous or conditioned malnutrition. There appears to be a general agreement that achlorhydria increases regularly with age in man. Ivy[2] indicates that achlorhydria is found in about every fourth person over the age of sixty. There is also general agreement that there is a decrease in the basal metabolic rate with age.

Even with these suggested changes in function, Keys says that there is practically no evidence that age, by itself, produces nutritional problems which do not have their counterparts at all ages in adult life.

From a survey of the literature it would appear that the investigators have scarcely found more than the beginnings of answers to such questions as what aging is and what cellular components are affected by the aging process.

Protein

As protein is often mentioned as one of the nutrients most likely to be inadequate in self chosen diets of the aged, it is of interest to review briefly some of the major investigations regarding the needs of the aged for this nutrient.

Roberts *et al*[5] reported they found that nitrogen equilibrium was possible in seven out of eight vigorous older women at intakes of between 0.7 to 1 gram of protein per kilogram of body weight per day, and there was no evidence that larger protein intakes were necessary or desirable.

Daum *et al*[6], in nitrogen equilibrium studies in older men, reported that five of seven subjects established equilibrium or storage on intakes of 1-2 to 1-6 grams of protein per kilogram of body weight per day.

Ohlson *et al*[7] point out that their studies on 18 older women appear to indicate that from 55 to 60 grams of protein daily was a marginal level for older women.

It would appear that the protein requirement of the aged is by no means accurately known. Davidson[8] says that it is difficult to believe that it is much different from that of younger individuals.

Keys[2] says that actually there is no evidence that the old man's protein needs are higher than those of the young man. He further states that the recommendation of a generous protein intake is defensible on the grounds that one should combat a common tendency of old people to choose a very high

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Food Service

sponsored by the

Canadian Dietetic Association

For references see page 74.

Provincial Notes

Quebec

MONTREAL. The St-Charles-Borromée Hospital, a hospital for chronically ill men, was recently opened officially by Cardinal Léger. When the building, a unit of the old Montreal General, is completely finished it will care for 600 patients. Its renovation and opening was made possible largely by volunteer workers.

MONTREAL. A campaign is under way to collect $4,500,000 for additions to the Queen Elizabeth Hospital. A new six-floor wing would allow for treatment of 5,000 more patients per year. Also enlarged would be the obstetrics, radiology, physiotherapy and pharmacy departments.

QUEBEC. A new addition to the Laval Hospital, recently inaugurated by Mgr. Maurice Roy, includes laboratories, bronchoscopy, eye, ear, nose and throat divisions, radiology, medical library and archives, consultation rooms, class rooms, and administrative and doctors' offices, thoracic surgery rooms, pharmacy, sterilization rooms, and five floors for patients' wards. Forty doctors comprise the medical staff.

Ontario

BARRIE. The board of directors of the Royal Victoria Hospital has presented plants to the town council for a proposed addition to the hospital and nurses' residence. Total estimated cost of the building expansion program and new furnishings and equipment is $1,072,000.

COCHRANE. New buildings and renovations costing $400,000 at the Lady Minto Hospital have increased the bed capacity by two-thirds, *i.e.* to 65 adult beds, 8 paediatric and 14 nursery bassinets. The maternity sections have been enlarged and a regular out-patient department opened. The x-ray equipment has been augmented and physiotherapy and isolation units added.

KINGSTON. Work has been started on a new tri-service military hospital near Kingston. The multi-million dollar project will have 125 beds and is designed for expansion to 600 beds. The hospital will be comprised mainly of private and semi-private beds. Included in the plans is a teaching centre for army medical staff and undergraduate medical students.

SOUTHAMPTON. The first sod for the new $175,000 addition to the Saugeen Memorial Hospital has been turned. The new wing will consist of 22 beds, a kitchen, laundry, nurses' and staff dining rooms, boiler and locker rooms. It is planned to have the wing completed by August 1957.

THORNHILL. A campaign has started to raise one million dollars to build the first wing of a 600-bed hospital at Thornhill to serve York County. The hospital, to be called Yorkminister, will be built on a 10-acre site. The first phase will be the building of a 100-bed hospital which will be expanded later to 600 beds.

WOODSTOCK. The new diagnostic pathology laboratory at the Woodstock General Hospital is now in operation. Equipped at a cost of over $2,000, it was greatly aided by a donation of $1,500 by the Oxford County Cancer Society. The new laboratory will assist the doctors in the area in the early diagnosis of cancer and other diseases.

Saskatchewan

EATONIA. Excellent progress is being made in the construction of the new Eatonia hospital. The main part of the hospital will consist of a full-size operating room and an out-patient department. The administrative and service wing will contain a dining room, kitchen, laundry, storage and a larger walk-in cooler. The hospital has a capacity of 11 beds, one bed being used as a complete isolation ward. The exterior of the building is finished in reinforced concrete slab. It will be ready for occupancy by March, 1957.

ILE A LA CROSSE. Plans for a 35-bed hospital here have been completed by the Saskatchewan architectural firm of Webster & Gilbert. The hospital will be owned by the St. Joseph's Mission.

PRINCE ALBERT. The city council has approved the establishment of a union hospital to operate in conjunction with the present Victoria Hospital. It is proposed to build a 75-100 bed extension at the Victoria Hospital at a cost of up to $1,000,000.

Alberta

CALGARY. A $1,422,741 north-south extension to the Calgary General Hospital has been approved by the city council. The extension will be started immediately.

CARDSTON. Plans are being made for the construction of a new municipal hospital at Cardston, to cost about $450,000. The building will be fully modern, of fireproof construction, brick and tile, with a central nursing station serving 34 adult beds, all in private and semi-private rooms, and six children's beds. The present hospital will be used as a home for senior citizens.

GRANDE PRAIRIE. A start on the construction of the $760,000 addition to Grande Prairie Municipal Hospital will be made next spring. To be built at right angles to the present hospital buildings, the new brick and steel structure will face west, presenting an almost solid expanse of glass on that side. The addition will make available another 32 beds, bringing the hospital's rated capacity to about 110 beds. The foundation will be strong enough to support an additional two storeys for which the architects have planned.

British Columbia

INVERMERE. The new Windermere District Hospital, which has been officially opened recently, is a T-shaped building with the south stem of the T housing the patients' wing and solarium, one arm housing the maternity wing and one the operating room and case room. Entrance to the building is on the north side with the administration offices in the centre. The institution has 24 beds and six cribs. The hospital was designed by architect Paul Smith of Trail. The adjacent eight-bedroom nurses' home is nearing completion.

NANAIMO. The Nanaimo hospital board is proceeding with plans for the construction of a hospital of approximately 200 beds to be built at an estimated cost of $3,000,000.

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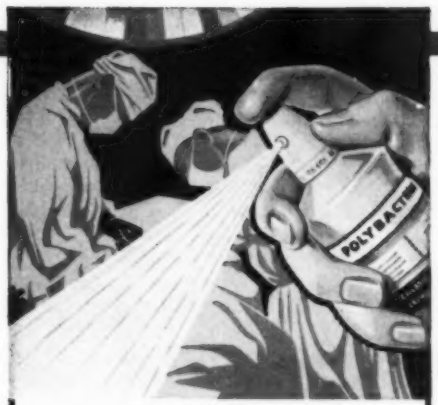

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Directors of C.H.A. Meet

THE FALL meeting of the Board of directors of the Canadian Hospital Association was held in Montreal, November 9th and 10th. The Board observed one minute's silence in tribute to the late E. V. Walshaw, a director, and former executive secretary of the Saskatchewan Hospital Association. To fill the vacancy left by the death of Mr. Walshaw, the board, under Article 26 of the association's by-laws, appointed Eugene Bourassa, of Regina, as a director. This appointment is effective until the next election of officers.

Education

The board approved several recommendations of the Committee on Education, including:

(a) That support of the W. K. Kellogg Foundation be sought with regard to the unexpended balance of their commitment for the five year period of the course in hospital organization and management. The unexpended balance to be used to review lesson material and revise where advisable, the writing of alternative examination questions, integration of the case study method for assignments and summer sessions, development of new bibliographies and the preparation of appendices to lessons.

(b) The 1957 summer session of the Extension Course in Hospital Organization and Management be held at the University of Manitoba, June 3rd to 28th, 1957, and that the summer session return to southern Ontario in 1958.

(c) Advise the W. K. Kellogg Foundation that a course for administrators of small hospitals, which is proposed by the Saskatchewan Hospital Association and the Department of Health of Saskatchewan has the board's complete approval and urged the Foundation to support the project.

(d) That the Canadian Hospital Association co-operate with the Canadian Nurses' Association in further consideration of the development of an educational program for nursing management in the hospitals and that, as an alternative to the extension course type of program, a series of institutes across Canada, in which some preparatory work and a form of follow-up would be incorporated, be offered for consideration.

(e) That no further action be taken on an extension course in hospital accounting until there is further evidence of need.

(f) That a valuable service to many hospitals in Canada could be provided by the collection and publication in pamphlet form of articles on in-service training programs. This to include the three articles published in the June and August, 1955, issues of *The Canadian Hospital*.

(g) That a memorandum be sent to associations and conferences regarding the feasibility of advanced institutes in hospital administration in order to learn their views so that the matter might be fully discussed at the 1957 biennial meeting.

(h) That the Canadian Hospital Association poll provincial associations to determine if they would be interested in having assistance in starting regional conferences or broadening those already in existence, and that the matter be referred to the assembly at the 1957 biennial meeting.

Accreditation

The board adopted three resolutions on the subject of accreditation:

1. RESOLVED that the Canadian Commission on Hospital Accreditation be advised immediately that the decision of the Canadian Hospital Association concerning an all-Canadian accreditation program and the target date for commencement of same must be made by the Assembly of the Canadian Hospital Association; the next meeting of which will be held in May, 1957.

2. RESOLVED that the board of directors of the Canadian Hospital Association recommend to the Assembly in May, 1957, that an all-Canadian program of hospital accreditation be inaugurated January 1, 1959, provided that the Canadian Commission on Hospital Accreditation submit a budget for such all-Canadian program that in the mind of the board of directors of the Canadian Hospital Association would be considered adequate.

3. RESOLVED that the board of directors of the Canadian Hospital Association request the Canadian Commission on Hospital Accreditation to submit such a budget for an all-Canadian program of accreditation at least three months prior to the biennial meeting of the Canadian Hospital Association in May, 1957.

Summary of Other Business

1. The board accepted a report of the executive staff recommending that in 1957 the Canadian Hospital Association co-operate with the American Hospital Association in sending out to Canadian hospitals one combined statistical questionnaire rather than two separate questionnaires as formerly.

2. Accepted a report by Murray W. Ross outlining the reasons why it has been necessary to revise the target date for the publication of the second edition of the *Canadian Hospital Accounting Manual*. The revised date is now the summer of 1957.

3. Finalized arrangements for holding the 1957 biennial meeting at the Bessborough Hotel, Saskatoon, May 27th, 28th and 29th. For the first time in the history of the association this meeting will be held in conjunction with the Western Canada Institute for Hospital Administrators and Trustees.

4. Appointed Dr. A. C. McGugan as chairman and Mgr. John G. Fullerton and Harvey Taylor as members of the nominating committee; and Gordon L. Pickering as chairman of the resolutions committee; Mother Ignatius and Dr. John B. Neilson as members.

5. Instructed the executive director to ascertain the present attitude of associations and conferences on the subject of unemployment insurance.

6. Appointed Dr. D. F. W. Porter and Eugene Bourassa as a committee to review the constitution and by-laws of associations seeking associate membership in the Canadian Hospital Association.

7. Agreed to support a memorandum of the Catholic Hospital Association in connection with certain aspects of the proposed plan of national hospital insurance and agreed to a joint committee of the Canadian Hospital Association and the Catholic Hospital Association of Canada to wait on the Minister of National Health and Welfare in connection with certain points in the proposed plan.

8. Accepted a report of the committee on constitution that since a great majority of organizations had indicated they had no recommendations or suggestions to make, the committee had concluded that the organizations in

(concluded on page 86)

Notes on Federal Grants

Construction

Hospital treatment and care facilities in several provinces are being increased with the aid of federal grants totalling over $400,000.

Hospitals in Ontario are to receive $360,000, of which $318,550 will go the Greater Niagara General Hospital, Niagara Falls, Ont. The grant will aid in the construction of an entirely new building providing accommodation for medical, surgical and obstetrical patients and out-patient services. The building will make available 264 new beds and 52 bassinets in cubicles. Also receiving federal aid is the St. Catharines General Hospital. A sum of $42,000 will aid in providing 84 additional nurses' beds at the nurses' residence.

British Columbia's hospitals are assisted by two grants. Campbell River and District General Hospital qualifies for a federal grant of more than $35,000 for 14 additional beds and 24 bassinets, to extend its acute medical, surgical, paediatric and maternity departments. The Stewart General Hospital, Stewart, receives $11,430 towards a nine-bed structure with facilities for radiology and treatment of in-patients and out-patients, as well as two nurses' beds.

The Lafleche Hospital, Lafleche, Sask., receives an $8,000 grant to aid in establishing eight beds, a nursery, and other facilities.

Jean Talon Hospital, Montreal, P.Q., is to receive more than $62,000 toward its extensive expansion program, based on the provision of 40 additional beds, 10 bassinets and 26 nurses' beds, as well as facilities for a school for nursing assistants.

Ladysmith, B.C., receives a federal contribution of some $42,750 for a new 35-bed and eight-bassinet hospital. The present 30-bed hospital will be torn down when the new facilities are available.

Mental Health

More than $880,900 has been allotted toward the cost of space for 530 beds and additional treatment facilities for the mentally ill at the Ontario Hospital, Kingston, Ont. The remainder of the cost is being met by the province.

A grant of $7,907 is being given towards the establishment by Laval University's Department of Psychiatry of a mental health clinic at Hôpital Ste. Marie, Three Rivers, P.Q.

An extension of mental health activities in western Nova Scotia is being supported by a federal grant of more than $17,000. The funds will be used to aid in the operation of a mental health clinic to serve an estimated 70,000 people in the counties of Yarmouth, Digby and Annapolis. Financial assistance is also being given by the provincial government and by Cornell University. The service will provide psychiatric services to this large area; make possible yearly examinations of all patients in county homes and hospitals not only in Yarmouth, Digby and Annapolis but also in Shelburne and Queens; and provide a follow-up service for patients discharged from the Nova Scotia Hospital.

Public Health

A $38,000 federal health grant has been allotted to Ontario to help finance a new tuberculosis detection program. The new grant will be used to assist in financing a chest x-ray for persons receiving old age assistance, blind and disabled persons' allowances, mothers' allowances and direct relief. Approximately 47,000 persons will be eligible for the new service at the outset. The program is voluntary and is not a condition for receiving financial assistance under any of these programs. Arrangement will be made to have the necessary x-rays taken in the out-patient departments of general hospitals, at chest clinic centres and sanatoria. In Metropolitan Toronto, Hamilton, Windsor, Ottawa, Belleville, North Bay, Sudbury, and Timmins, it is expected that the expanded detection program can be carried on by existing tuberculosis control agencies. The federal grant will make possible the extension of this work to other centres throughout the province.

A further grant of $8,000 is being provided for an addition to the biochemistry laboratory of the Victoria General Hospital, Halifax, N.S.

Rehabilitation

A grant of $16,745 is being used to extend and improve medical rehabilitation work in New Brunswick. These services will be provided chiefly at the Polio Clinic and Health Centre at Fredericton.

Research

Saskatchewan has received a federal grant toward a four-month training course in neurosurgical nursing for Monica Tremblay to assist in developing such services at the University Hospital, Saskatoon.

Opening of Penicillin Plant Built by India with UN Aid

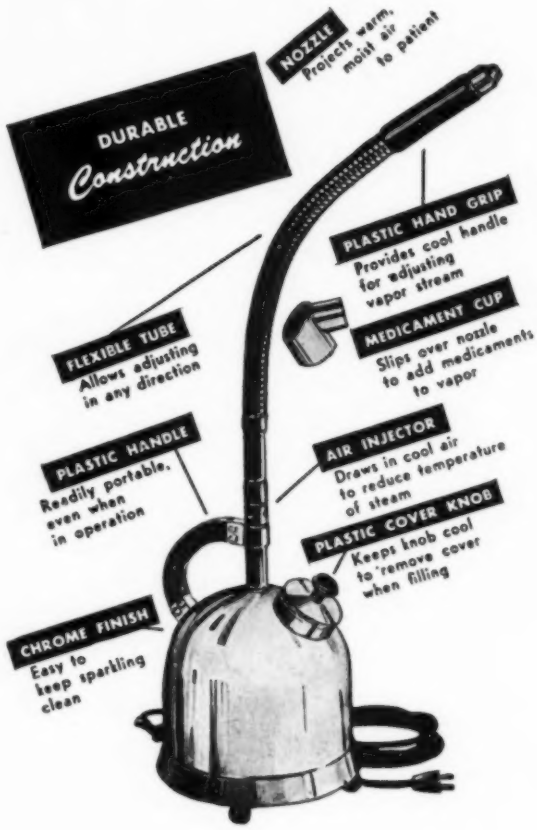
Opened recently was a $4,000,000 penicillin plant at Pimpri, India, 10 miles from Poona in Bombay State, built with assistance from the United Nations Children's Fund and the UN Technical Assistance Administration.

The Government of India provides the technical staff for the project and has borne the entire expense of land and building construction. UNICEF supplied $850,000 in machinery and precision equipment for the factory and its control laboratories. The UN Technical Assistance Administration arranged for the training of Indian technical personnel abroad and also provided foreign technical experts for designing, erecting and bringing the production plant into operation. The TAA contribution has totalled $300,000 and has been provided under the Expanded Program of Technical Assistance of the UN and the specialized agencies.

The eventual capacity of the plant at Pimpri is anticipated at 2,500 pounds of penicillin per month. At this time the first production target of over 1,000 pounds monthly has been reached. This amount can now meet only one-third of India's need for penicillin, UNICEF has been informed. —*U.N. Dept. of Public Information.*

Science keeps down the weed of superstition, not by logic, but by rendering the mental soil unfit for its cultivation.—*Tyndall.*

THE MYRICK INHALATOR



Note: Action of air injector can be demonstrated as follows: Start Inhalator in operation and when vapor is being projected from nozzle, wrap a handkerchief or other material over the four holes in tube just above handle. This cuts off air supply and steam coming out of nozzle will not be projected. Remove handkerchief and notice how vapor is again projected.

Entire contents of Inhalator must come to a boil. Warm up period can be reduced by filling with hot water.

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With the Auxiliaries

Energetic Auxiliary Aids New Hospital

A sum of $10,000 has been donated by the women's hospital auxiliary of the Brantford General Hospital, Brantford, Ont., toward the furnishings of the dining room in the new cafeteria. In addition, the auxiliary is planning to install a tea room and gift shop in the main wing of the new hospital.

This energetic group, since its organization in 1903, has contributed a sum of approximately $302,000 to various capital projects. The rooms of the student nurses have periodically been renovated, with changes of draperies and furniture. Holiday treats are provided throughout the year for both nurses and patients.

In their present tea room and gift shop, during the past year, 178,521 customers were served. A canteen is also operated at the nurses' residence for the convenience of the nurses. A mobile canteen for the patients made a total of 220 visits during the past year. This, together with their travelling library, brings to the patients a much needed service and friendly contacts which do much for the morale of long-stay patients.

Among the activities of this group are an auction sale, sewing, talent money, a fall tea, rummage sale, special June letter replacing tag day, catering for luncheons, and monthly news letter, bringing highlights of the auxiliary's activities and items of interest concerning the hospital to their 300 members.

* * * *

To Purchase Equipment

More than $900 was raised in a joint tag day sponsored by the Nurse Essex and South Burnaby women's auxiliaries to Burnaby General Hospital, Burnaby, B.C. Proceeds will go towards purchase of equipment for the proposed 125-bed addition to the hospital.

* * * *

Bursary to be Given To Nursing Student

The women's auxiliary of the Barrie Memorial Hospital, Barrie, Ont., has set up a bursary fund to give financial assistance to girls who desire to become registered nurses. The bursary, which will be granted annually, provides for enrollment and outfitting expenses up to $200 for the successful applicant and a monthly allowance of $10.00 during her entire three years in training. Graduates receiving this financial assistance will be expected to work for at least one year at the Barrie Memorial Hospital following graduation.

* * * *

Promote Children's Interest

The ladies auxiliary of the Huntingdon County Hospital, Huntington, P.Q., has a plan for trying to promote the interest of the children in the hospital. They are going to visit the schools throughout the county with a view to having each child donate a small sum of money to a fund which will be used to replace furnishings in the children's ward of the hospital. The money has to be a sum which the child himself has earned in some small way.

* * * *

Saskatchewan Convention

The election of officers climaxed the two-day convention of the Saskatchewan Association of Hospital Women's Auxiliaries, held in October in Saskatoon. Reports, guest speakers, general business and coffee parties kept delegates busy. Officers for this year are: *President*, Mrs. W. C. King, Estevan; *Past president*, Mrs. J. N. Adams, Tisdale; *First vice-president*, Mrs. A. R. Salzgeber, North Battleford; *Second vice-president*, Mrs. P. I. Korman, Saltcoats; and *Third vice-president*, Mrs. W. Dier, Prince Albert; *Secretary-treasurer*, Mrs. K. W. Turner, Estevan.

* * * *

Solarium for Crippled Children

Commanding a view of three-quarters of Calgary, Alta., is a new solarium on the third floor of the Alberta Red Cross Crippled Children's Hospital. Financed by the Children's Hospital Aid Society, it cost them $37,000. Boys and girls who do not ordinarily get out to play can almost believe they are out of doors when playing in the spacious and well-lighted addition, a room 90 by 40 feet enclosed on two sides by glass walls, and opening on to a sun deck 45 feet long. Colourful drapes in modernistic print hang from either side of the glass enclosures and set off the brick effect of the walls. A folding, mobile stage can turn the solarium into an auditorium where plays and variety programs can be presented for the children.

* * * *

Variety Sale Successful

Approximately $1,200 was realized from the annual variety sale of the ladies hospital aid society, Amherst, N.S. This money will be used for the purchase of linens and other items for the Highland View Hospital and to aid in the furnishing of the graduate nurses' home and the student nurses' residence.

* * * *

New Group Well Organized at Cranbrook, Nfld.

Nursery furnishings and unbreakable toys for the children's ward; a bedside wagon with cigarettes, candy, combs, and writing paper for sale, which will tour the wards every day; a canteen for out-patients; flowers and shrubs for the hospital grounds; hospital "showers" of home-made jams and pickles; a group to welcome new nurses and introduce them to Cornerbrook; volunteers to visit young out-of-town patients; all these and many more are the projects which will be undertaken by the new Ladies' Auxiliary of Western Memorial Hospital, Cornerbrook, Nfld., which was formed very recently. Letters have been sent out to all business houses throughout the west coast of the province, announcing the advent of the organization and asking their support in any way possible. The Girl Guides offered to start a project to collect and refurbish old toys for the children's ward for Christmas and the ladies of Beta Sigma Phi will provide a welcome for new nurses coming to the hospital.

* * * *

Dance Proceeds Total $4,800

Approximately $4,800 was realized at a recent ball held by the Women's Auxiliary to the Health Centre for Children, Vancouver General Hospital, Vancouver, B.C. The auxiliary has also donated playpens, toys and viewmasters to the Health Centre and volunteers entertain the children in the wards.

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*Talbot, N. B., Crawford, J. D., and Butler, A. M., "Homeostatic Limits to Safe Parenteral Therapy." New Engl. J. Med., 248, 1100 (1953).

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Let's Look at Education
(concluded from page 47)

Geographical Classification
1956-57

	Graduates of	Students	
	2-yr. Course	2nd Year	1st Year
British Columbia	10	4	11
Alberta	4	3	—
Saskatchewan	3	6	4
Manitoba	1	4	3
Ontario	19	6	14
Quebec	10	5	9
New Brunswick	8	—	2
Nova Scotia	1	1	3
Prince Edward Island	1	1	1
Newfoundland	1	—	1
	58	30	48

Extension Course
For Training Medical Record Librarians

Size of Hospital

	Students		
	2nd Year	1st Year	Total
50 and under	7	7	14
51-100	6	9	15
101-200	7	14	21
201-500	7	8	15
Over 500	2	8	10
Cancer Institute	1	—	1
Department of National Defence	—	1	1
Medical Clinic	—	1	1
Total number of students in 1956 classes—74			
Requiring only intramural session— 4			
			78

pressive amount of work in addition to their responsible and busy positions.

There were 19 hospitals from coast to coast which conducted intramural sessions for those students during the summer months of 1956. Each student who successfully completes the work of the winter session is assigned to a hospital for a 4-week intensive course under the supervision of the medical record librarian there. These sessions have been highly successful, due to the co-operation of the hospital administrator and the chief medical record librarian where they are conducted. Students get an opportunity not only to learn the practical application of the lesson material, but to compare the entire system at their own hospital with the one in use at the teaching centre.

Some charts have been prepared for your perusal; they show the geographical distribution of students and graduates of the course, the size of hospital, and the age and academic background of first-year students. It will be evident that certain areas are represented better than others; it is hoped this will be remedied in the future by more applications of the required standard from the parts of Canada where only a small number have participated.

Graduates of this program who have an additional year's experience and the basic educational qualifications required may write the registration examination of the Canadian Association of Medical Record Librarians. Fourteen did so this year and eleven one year ago; the standard of the results was gratifying to the people who operate the program. This extension course was designed to fill a particular need, the training of enough qualified medical record librarians to form a satisfactory core of such workers for Canadian hospitals and clinics. This is far from being completed, but the beginning has been an auspicious one, and the faith of the industrious people who undertook the promotion and inception of such a program has been rewarded already. Let us hope that the executives of Canadian hospitals will support this program actively so that the problem of obtaining well-trained medical record librarians in sufficient numbers will be but temporary.

Analysis of First-Year Admissions

Classification:	1953	1954	1955	1956
Total Students	42	49	40	48
Age Groups:				
Under 21	1	2	3	3
21-30	12	16	11	9
31-40	18	18	12	18
41-50	8	10	12	13
Over 50	3	3	2	5
Academic Status:				
Below Junior Matriculation	6	11	11	5
Junior Matriculation	20	25	16	29
Senior Matriculation	14	12	12	13
University Degree	2	1	1	1
Registered Nurses	12	8	8	14
Sisters	13	10	14	14

Canadian Medical Mission for India

As part of Canada's Colombo Plan contribution, a Canadian medical mission is to visit India to present lectures, give clinical demonstrations and discuss professional training in Indian medical colleges.

The mission will consist of two teams of noted medical men, under the leadership of Dr. Wilder Penfield, director of the Montreal Neurological Institute and professor of neurology and neurological surgery at McGill University. The two teams, a medical teaching team and a tuberculosis team, are made up of noted specialists from across the country.

The medical team will spend three months in India, one month at each of three leading medical colleges. Similarly, the tuberculosis team will visit three teaching institutions over a period of approximately six weeks. The tuberculosis team left at the end of December in order to represent Canada at the 14th International Tuberculosis Congress, held in Delhi from January 7 to 11. The medical team arrived in India around January 10 and will be occupied there until late March.

Dr. Penfield will be visiting and lecturing in Karachi, Pakistan, and Colombo, Ceylon, as well as in India.

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Maritime Hospital Association Holds Administrative Institute

An institute for hospital administrators, sponsored by the Maritime Hospital Association, was held at the Victoria General Hospital, Halifax, N.S., November 27th to 29th, 1956. This was the fourth such institute which the Maritime Hospital Association has conducted. The meeting was an outstanding success—not only were the papers presented of a high calibre — but group discussion was very much in evidence.

The following subjects were presented: "Safety Procedures in Hospitals", K. J. Partington, Provincial Fire Marshall; "Renovations and Alterations in Existing Hospitals", H. Gordon Hughes, chief, Hospital Design Division, Department of National Health and Welfare, Ottawa; "Hospital Reports and Statistics by Administrators to Boards of Management", Walter W. B. Dick, Moncton, chairman of the Accounting Committee, Canadian Hospital Association; "Medico-Legal Problems in the Hospital", H. P. MacKeen, Q.C., Halifax, N.S.; "Staphylococcus Infection in Hospitals", Dr. M. R. MacDonald, assistant superintendent, Victoria General Hospital; a panel on nursing problems with Sister Catherine Gerard, superintendent of the Halifax Infirmary as moderator; "Sharing of Qualified Specialist Personnel by Smaller Hospitals", Dr. D. F. W. Porter, hospital consultant, Bathurst, N.B.; "Disaster Planning", Dr. Gordon Fryer, National Health and Welfare, Ottawa; "Radiological and Laboratory Services Under Federal and Provincial Health Grants", Dr. O. C. MacIntosh, director laboratory and radiological services, Province of Nova Scotia; "Drug Control in Smaller Hospitals", M. Harris, pharmacist, Children's Hospital, Halifax; "Medical Staff Organization in Smaller Hospitals", "Blue Cross Contract Developments", "Presentation of Rorem Report to Administrators" all by Dr. J. A. MacMillan, Charlottetown, P.E.I.

A panel of speakers discussed various problems of special patients in smaller general hospitals. Dr. R. O. Jones, Professor of Psychiatry, Dalhousie University, dealt with mental patients. Dr. E. M. Fogo, Director of Communicable Disease Control, for the city of Halifax, outlined problems with infectious patients and Dr. G. J. H. Colwell, specialist in physical medicine, spoke on geriatrics and physical medicine.

Discussion leaders for the Institute were: F. C. MacGillivray, Chief Halifax City Fire Department; Dr. Hugh McKay, chairman N.S. section, New Glasgow; C. F. Matheson, Colchester County Hospital, Truro; Dr. Carl Trask, Director, Saint John General Hospital, Saint John, N.B.; Dr. C. E. van Rooyen, Professor of Bacteriology, Dalhousie University; Mrs. Margaret MacLean, Glace Bay General Hospital; F. H. Silversides, Children's Hospital, Halifax; E. S. Blackie, Halifax, N.S.; E. O. Hodge, Yarmouth Hospital, Yarmouth, N.S.; John D. Mosher, Blanchard-Fraser Memorial Hospital, Kentville, N.S.; Jeanne Murdock, Sackville General Hospital; Dr. W. Douglas Piercey, Executive Director, C.H.A., Toronto.

The following acted as chairmen at various sessions: Dr. C. M. Bethune, Victoria General Hospital; Frank Silversides, Halifax; Dr. T. E. Kirk, Camp Hill Hospital, Halifax, Sr. Paul of the Cross, Antigonish, N.S.; Dr. A. M. Clarke, Moncton Hospital; and R. H. Stocker, president, MHA, Fredericton.

During the three-day session, field trips were conducted at Grace Maternity Hospital, the Children's Hospital, Rehabilitation Centre of the Provincial Welfare Council, Camp Hill Hospital and the Halifax Infirmary.

The Chairman of the Institute was Dr. C. J. Macdonald of Camp Hill Hospital and the committee members were: Sr. Catherine Gerard, R.N.; Sr. Marion Estelle, R.N.; Sr. Frances de Paul, R.N.; Sr. Margaret Clare, all of Halifax Infirmary; Brigadier Atkinson, Major LaRose and Major Strickland of Grace Maternity Hospital; Dr. C. M. Bethune and Dr. M. R. MacDonald of Victoria General Hospital, and F. H. Silversides, Children's Hospital.—*W.D.P.*

For Trustees Only

(concluded from page 52)

lic hospitals in a tight squeeze. Industry, generally, raises the price of its products to compensate for increases in costs which are brought about by wage increases and other factors. In fact, industry has been accused of unfairly raising prices above the compensatory figure. Our public hospitals are not operated on a cost-plus basis. Fees and charges have been raised, it is true, but, as you all know, not to a basis which would ensure a loss-free operation.

What I have outlined are what might be termed the indirect effects of the trends in industrial relations on hospital administration. Now let us look at the direct effects.

The smaller hospital in particular, and all hospitals in general, because of the very nature of their work, operate as compact units, with a degree of team-work and loyalty not common in industry generally. With the new concept in union organization, the entrance of a union into a hospital is bound to make a perceptible impact on these relationships. I do not for an instant imply that there is any less loyalty or teamwork. What I want to emphasize is that with the advent of the union and the union agreement, there is established a strictly formal procedure for the handling of employee relations. This may be a good thing in some instances —perhaps employee relationships were on too informal a basis. With a union agreement, spelling out the methods to be used in these relations, close adherence to these rules becomes imperative, and informal mutual arrangements contrary to the agreement, must cease. There becomes a greater differentiation between employer and employee because of the establishment of the formal procedure.

Whether any departments of a hospital are unionized or not, the effect of the trends which I have outlined has already been felt, because shorter hours and increased benefits have been put into effect. If these trends continue, hospital costs will rise steadily. Hospital rates will have to keep pace, to some extent at least, thus increasing the financial burden of the patient or of the prepaid medical and hospital plan. In either case, the patient pays more. In the final analysis, the patient and the hospital are caught in the spiral which seems inevitable at present.

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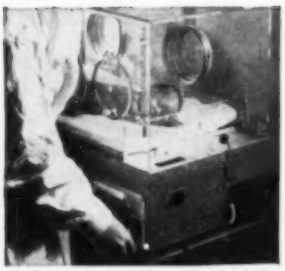

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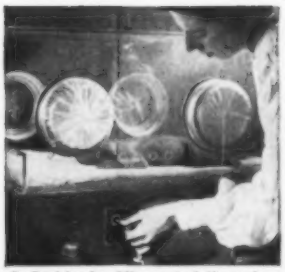

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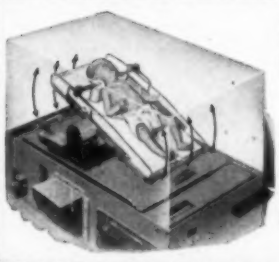

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You Were Asking
(continued from page 51)

tends to defeat the purpose for which the hospital exists, hence the question should be answered from the principle of specific need, rather than hospital policy.

Today, therapeutic equipment is supplied through local rehabilitation centres and the Canadian Red Cross. Demands on hospital equipment have been reduced almost to a minimum, but occasionally an urgent request presents a challenge to us to exercise our charity—*Sister Mary Fabian, St. Clare's Mercy Hospital, St. John's, Nfld.*

THE hospital's first responsibility is to the patient, and that responsibility does not necessarily end when the patient has been discharged. If the patient requires equipment to assist him, then in my opinion it should be loaned, providing it does not inconvenience patients that are in hospital. I think the hospital should have available various items of equipment that are likely to be needed, which can be rented at a nominal charge to cover depreciation.

We should bear in mind that if this is done it could have the effect of freeing hospital beds earlier. The same, I think should apply to out-patients, and even to patients of members of the medical staff who have not attended hospital. After all, it would be extremely difficult for an individual to obtain some items of equipment and the hospital should, I think, be prepared to render assistance wherever possible.—*Kenneth E. Box, Belleville General Hospital, Ontario.*

IT IS our policy to loan equipment on an emergency basis only. Obstetrical packs, instruments, oxygen equipment, resuscitators, intravenous sets, solutions and emergency drugs may be issued on the request of a member of the medical staff with the definite understanding that it is for emergency only. The physician is responsible for the equipment. A detailed signed report goes to the superintendent and the central supply supervisor.

This procedure applies to:

(a) Discharged patients. Emergencies may arise requiring equipment, until the patient can be readmitted or equipment obtained from a rental agency.

(b) Out-patients. Crutches only, on a rental basis.

(c) Patients of the medical staff who have not been in-patients. Emergency only. The physician decides what is an emergency and realizes that abuse of this privilege will mean discontinuing the policy as it now stands.—*Alice J. Little, Niagara Hospital, Niagara-on-the-Lake, Ont.*

THE reply to (a) and (b) is "yes". We must be of the greatest possible service to *all* our patients. Financial circumstances of the patient and the type of equipment govern our policy. Equipment which can be obtained by patients from the Red Cross loan depot here, or from medical equipment rental firms such as hospital beds, wheel chairs, walkers, bed pans, et cetera, are not loaned by the hospital. Crutches, canes, and other pieces of minor equipment such as catheters, tensor bandages, et cetera, are loaned to patients. The full value is charged and a deposit taken if the circumstances of the patient permit. Crutches and canes are rented on a set scale at a minimum monthly or part of a month rate.

The balance of the unused deposit is refunded when the appliance is returned. Indigent and welfare cases are not charged rental. Our accounts receivable division keeps a record of items on loan.

The answer to (c) is "no". They are not our patients. — *R. A. Williams, White Rock District Hospital, B.C.*

THE answer to (a) is generally "no". We believe that if the equipment is required for treatment then the patient is not ready for discharge or should return and be treated as an out-patient. If it is a piece of equipment forming part of a cast, then the patient may be discharged with the equipment, but is charged in full for it and a refund is made on its return. Wheel chairs, et cetera, may be provided by service clubs. In the case of oxygen equipment and cylinders, we ask the patient to make arrangements with his doctor —in this case the physician purchases the equipment for the patient and charges him. This frees the hospital from responsibility and financing, not to mention collection. The same answer applies to parts (b) and (c).

It is unwise to lend hospital equipment since it *is* hospital equipment and many complications can follow. Injury from faulty equipment, for example, regardless of what release has been signed by the patient or individual concerned, must be kept in mind.— *Roman E. Mann, formerly administrator, Alexandra Hospital, Ingersoll, Ontario.*

New Rabies Treatment

The effectiveness of serum plus vaccine in preventing rabies has been accepted by the third World Health Organization Expert Committee on Rabies which met at the Pasteur Institute in Paris recently. It is some 70 years since Pasteur introduced rabies vaccination for human beings and the combined technique is one of the notable advances in the prevention of rabies since that time.

A new technique for protecting persons whose occupations expose them to the possibility of bites by rabid animals was delineated by the committee. Veterinarians, laboratory workers, postmen, personnel of gas and electric industries, and delivery services, must often undergo repeated treatment with rabies vaccine, which carry a danger of post-vaccination complications.

The new approach involves providing basic protection by giving very small doses of chicken embryo vaccine, or a few doses of ordinary nervous tissue vaccine, followed by a single booster dose of vaccine after they are bitten, instead of the long (14-21 day) schedule of innoculations now performed.

Rabies in wildlife, particularly in foxes, jackals and wolves, is a problem in many countries. It also exists in insectivorous bats in areas of North America and it is known that rabies is transmitted to men and animals in Latin America by blood-sucking bats. Wild animal reservoirs present special difficulties and rabies control is of concern to public health officers in Canada. — *Pan American Sanitary Bureau, World Health Organization.*

Twenty Years Ago

("Canadian Hospital", January, 1937)

QUEBEC.—Early organization, into one body, of all departments of hygiene and health in the Province of Quebec was predicted recently by J. H. A. Paquette, Provincial Secretary. The thirty-five health units in the province will be increased in number, so that there will be units in all districts of the province. An early investigation into the admission of indigents into various institutions was announced. The replacement of nurses, at colonization centres, by young doctors was also forecast, the government being ready to pay $100 a month to young doctors desiring to accept positions.

TORONTO, ONT.—The general distribution of protamine insulin by the Connaught Laboratories is anticipated early in the new year. This has been available for some months in experimental quantities, and its enthusiastic reception by the profession augers well for its widespread use, when distribution becomes general.

TORONTO.—The establishment of birth control clinics in connection with hospitals especially in all tuberculosis institutions, and the inclusion of instruction on the subject in nursing school curricula, are among the activities being considered by the recently formed Toronto League for Race Betterment. This organization, which is sponsored by a group of prominent citizens of Toronto, aims to provide education with respect to the birth control movement and racial benefit, to encourage establishment of properly supervised centres and clinics and to investigate all sociological and scientific data bearing on the sterilization of the mentally unfit.

LAKE WINDERMERE, B.C.—The Honourable and Mrs. Bruce have offered their former home "Pynelogs" in Invermere as a new hospital for the Windermere district. They have offered to remodel and equip the building as a hospital as part of the gift. The offer was unanimously accepted, and the new hospital will be called the "Lady Elizabeth Bruce Memorial Hospital" . . . .

The University of Toronto School of Nursing, which has blazed a new trail in the education of nurses-in-training, held its first graduation exercises recently, when Miss Jean Leask, B.A., Moose Jaw, Sask., Miss Mary Thom, B.A., Regina, Sask., Miss Marion Plaunt, Sudbury, Ont., Miss Rosella Cunningham, Cobourg, Ont., and Miss Nora Yeo and Miss Haslam, Toronto, Ont., received diplomas for successfully completing the new three-year course.

An 8-room hospital is to be built 70 miles from Peace River, Alberta, by the United Church, according to an announcement made recently in Edmonton.

St. Mary's Hospital, Timmins, Ontario, is to have a new nurses' residence providing accommodation for 45 nurses, and costing with equipment, in the neighbourhood of $60,000. This will release 30 more beds for patients, giving the hospital a capacity of 105 beds.

Nobody can lead unless he has the gift of vision and the desire in his soul to leave things in the world a little better than he found them.— *King George VI.*

"WHEN A HUMAN LIFE MAY BE AT STAKE, THERE CAN BE NO COMPROMISE WITH QUALITY"

How to Join

(concluded from page 50)

likely to advance them if admitted to membership.

We hope this article will reach the hands of anyone so interested, perhaps through the thoughtfulness of some hospital administrator who may be reading it and thinks to pass it on. Many medical record librarians are so located geographically that it is impossible to attend provincial association meetings, but long to share problems and discuss matters of mutual interest with fellow workers in the medical records field. This may be done through the medium of the *Bulletin* for every contribution will be welcomed from members, regardless of their membership classification.

If you are interested in joining the association, send your name and address to the chairman of the membership committee, Mrs. Virginia D. Stannard, R.R.L., Medical Records Dept., Vancouver General Hospital, Vancouver 9, B.C.

Protein Requirements

(concluded from page 53)

carbohydrate diet — grandmother's toast and tea regime.

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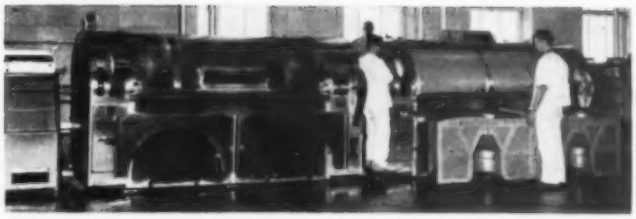
UNKRA Grants $22,000 to Hospital in Pusan

The United Nations Korean Reconstruction Agency has made a $22,000 grant to the new memorial hospital being built by the Maryknoll Sisters at Pusan, Korea. The contribution will assist in the establishment of a Paediatric Nurses Training Department. At present, the Sisters attend to some 1,900 out-patients a day at their clinic in Pusan and also offer paediatric training courses for nurses on an out-patient basis. The 160-bed hospital, which will be completed this year, is being built and equipped by Armed Forces Aid to Korea and the Maryknoll Sisters. Plans include a teaching program for interns, pharmacists, laboratory technicians and nurses.



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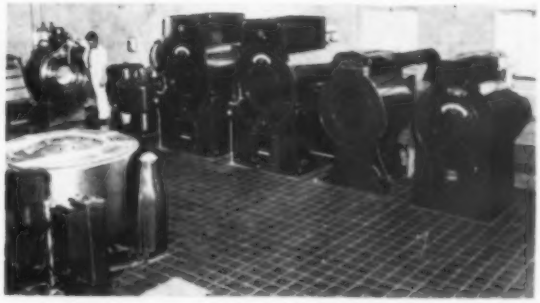

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Hospital Challenge
(concluded from page 35)

far devised is the development of a regionalized hospital system, recommended by all the provincial health survey committees. It is not enough that health departments understand and encourage the development of this concept. It is up to leaders in the hospital field to take the initiative.

4. In addition to the obligation resting on the individual hospital, on city or regional hospital councils, on provincial hospital associations, responsibilities also rest on the national hospital association. You must also make your influence felt there, for each province of Canada has an obligation to the whole nation. With the prospect of a national hospital insurance program, the challenge to national leadership becomes even greater. This requires, as noted earlier, a broadening of your responsibilities and a commensurate raising of your sights. It seems to me, as a political scientist concerned about the relations of voluntary groups to government in a democracy, that you must take time out from your daily pressing problems and launch a full scale analysis of your functions and your role in society.

When you have ascertained these functions and stated them in clear and unequivocable terms, you must then ask: "What are the absolute essential conditions that will secure and safeguard the continuation and improvement of these functions?" On these you must be prepared to fight, to give no ground. But it would be folly for you to fight on issues that are not fundamental, for you thereby run the risk of losing on those matters that are fundamental. Having determined on the fundamentals, of course, it is imperative that your political organization, your association, be strong and well organized. And this, too, calls for statesmanship of a high order.

In the past, the hospital has been busy perfecting its scientific knowledge and its technique. It was involved in perfecting its product. That product, while still to be improved, has now reached the stage where its efficient and economical distribution is the most urgent need. This calls for leadership of a new order. If responsible members of hospital associations apply to this great new task the same calibre of leadership that they have applied to the development of their institutions and the formation of their most excellent associations, then those of us who are potential patients, Blue Cross subscribers, and tax-payers can rest assured that our interests are being well served.

Investigation of Abnormal Drivers

A little known, but serious and necessary part of the operation of the Motor Vehicles Branch of the Highways Department, Ontario, is a five-man medical board, whose duty it is to investigate, review and judge cases of mental and physical abnormality among drivers. Composed of four neuropsychiatrists, two from the Department of Health and two private practitioners and an official of the Motor Vehicles Branch, the board's recommendations on whether a person is fit to operate a vehicle are always acted upon by the Department of Highways. *—Ontario Government Services.*

C.A.M.R.I.

(concluded from page 49)

N.B., was installed as president for 1956-57. Dr. George Turpin, padre of Shaughnessy Veterans' Hospital, Vancouver, B.C., was guest speaker at the banquet.

Many thanks are due the arrangements committee for the success of the convention at which western hospitality and friendliness were much in evidence. We hope it will not be too many years hence until the convention is again held on the west coast.

Officers

President—Margaret Heenan, Saint John, N.B.

President-elect: Dr. Margaret McGuire, Winnipeg, Man.

First Vice-president: Ann Rackham, Winnipeg, Man.

Second Vice-president: Sister Mary Mercedes, Antigonish, N.B.

Secretary: Frances Eagles, Moncton, N.B.

Treasurer: Sister Annonciade Saulnier, Campbellton, N.B.

Councillors: Barbara Hawken, Oakville, Ont.; Mrs. Ruth Melby, New Westminster, B.C.; Sr. Margaret Clare, Halifax, N.S.; Sr. Kathleen Keevil, Kingston, Ont.; Mrs. Elizabeth Neilson, and Marjorie Riddell, Toronto, Ont.

Coming Conventions

May 24-25—Board of Directors, Canadian Hospital Association, Bessborough Hotel, Saskatoon, Sask.

May 26-30—Canadian Society of Laboratory Technologists, annual convention, Astor Hotel, Vancouver, B.C.

May 27-28—Biennial Meeting, Canadian Hospital Association, Bessborough Hotel, Saskatoon, Sask.

May 27-30—Catholic Hospital Association Convention of the U.S.A. and Canada, Hotel Statler, Cleveland, Ohio.

May 28-31—Western Canada Institute for Trustees and Administrators, Saskatoon, Sask.

May 29-June 4—Quadrennial Congress of the International Council of Nurses, Rome.

June 3-7—International Hospital Congress, Lisbon, Portugal.

June 17-21—Canadian Medical Association, annual meeting, Macdonald Hotel, Edmonton, Alta.

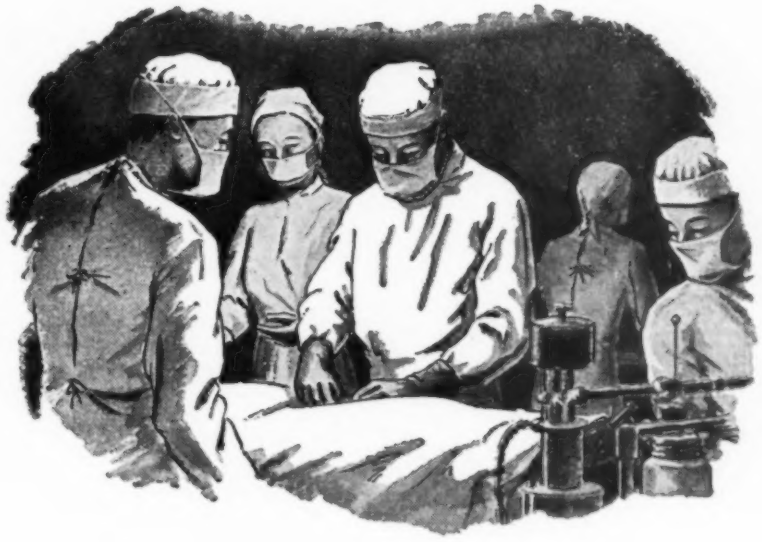
Sept. 30-Oct. 3—American Hospital Association, annual convention, Hotel Traymore, Atlantic City, N.J.

Oct. 14-17—British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Oct. 28-30—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.

National Hospital Week

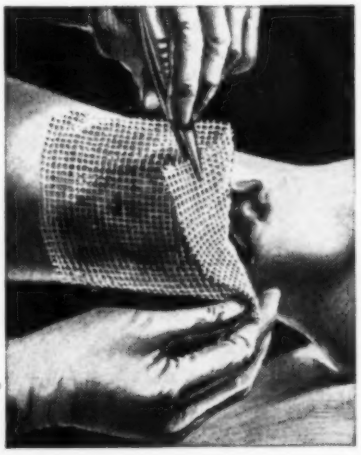
According to an announcement by the American Hospital Association, National Hospital Week will be observed this year from May 12th to the 18th. Now is the time to start planning to celebrate, if not a whole week, at least one National Hospital Day, May 12th.



Prevention of Dressing Trauma

Jelonet is a dressing for all wounds—its non-adherent properties protect the delicate epithelium and prevent dressing trauma, enabling healing to continue undisturbed. It is used extensively in the treatment of burns and as a dressing following skin-grafting operations. Other uses include: drainage, packing for deep granulating wounds, and as an adjuvant in the treatment of varicose ulcers by compression bandaging.

Jelonet is available in the following sizes:—tins of 36 pieces, tins of 5 pieces, tins of 10 pieces, and cartons of 12 individually enveloped. Each piece 3¾″ x 3¾″



A special size tin containing a strip 8 yards long x 3¾″ wide, folded zig-zag, is available for Hospitals and Surgeries. All sterile—ready for immediate use.

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Blue Cross as Social Force

(concluded from page 45)

surance industry including group experience rating and unlimited variations in contract benefits, the support of Blue Cross by the community declined and ceased to exist altogether. The public image created by the plan was that of insurance—and a small local insurance company at that.

Apparently without knowing it some of our plans sold their birthright to community support for a mess of commercial pottage, or, to use another biblical metaphor, they cast down the Commandments of Moses and began to worship the golden calf of an alien tribe.

For an illusory immediate gain of conserving or securing the enrollment of a special group, broad principle was sacrificed by such plans. The long term good of the community, the hospital and the individual was bartered for a transitory and temporary gain. The pressures are constant for Blue Cross to descend from the competitively unassailable high plateau of community service to the lower ground of daily competition for business with commerce and industry—an area in which the insurance companies are deeply entrenched. On such terrain our resources are inadequate for the battle. Our prospects of ultimate victory nil.

But when the real community purpose of Blue Cross is understood by the hospital, the plan adequately presented and properly identified to the public; when its contract benefits stated in simple, understandable terms provide adequate service benefits at the ward and semi-ward level; when the community social aspects of the plan have been emphasized and the original principles and concepts of Blue Cross adhered to; Blue Cross can and does meet the needs of people and the hospital.

The future of Blue Cross is what the providers of health service want to make it. The decision will largely be made by the hospitals and by the doctors. The choice will either be Blue Cross or government—commercial insurance cannot and will not solve the problem or meet the need. A choice by the hospital in favour of traditional idemnity insurance is really a choice for a government plan. When you choose the government you take a step which cannot be retraced — an action that is irretrievable. Security in the area of health care will be achieved; and, if it cannot be achieved by the community through plans supported by the hospitals and by the doctors who supply the services, then it will be secured through the government.

International Hospital Congress

Arrangements for the meeting of the Tenth International Hospital Congress, to be held in Lisbon from June 3 to 7th, 1957, are being made. The theme of the congress will be "International Co-operation for Hospital Development." It is hoped that representatives of hospitals all over the world will bring their problems and the benefit of their experience to this international forum. *I.H.F. News Bulletin.*

The PRAGEL PORTABLE INCUBATOR

saving premature infants throughout the world

Many leading hospitals are now using the Pragel Portable Incubator either as emergency supplementary stationary equipment, or to carry infants between the premature nursery and other sections of the hospital, such as X-ray, operating rooms, etc. The convenience and versatility of this incubator make it an important addition to standard hospital equipment.

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A half-century of manufacturing knowledge and research and the best medical advice dictated the design features of the Pragel Portable Incubator. It is made of light-weight aluminum, compact, easy to handle, and yet is very rugged and affords the greatest safety for the infant.

Sliding unbreakable Plexiglas windows on both sides permit the physician or nurse to attend the infant without removing it from the incubator.

A built-in thermometer, visible from the top, gives the interior temperature.

The width of the crib accommodates twins comfortably, triplets in an emergency.

Simplified heating and oxygen supply

Heating is simplified through use of hot water bottles, which when placed in designated positions, provide the infant with needed warmth without fear of direct contact. Batteries and other mechanical devices have been purposely rejected in favor of the reliability and ready availability of hot water regardless of locality. Humidified oxygen is supplied by means of a 40-gallon oxygen tank (B cylinder) and humidifier attached to the side of the unit.

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Nursing Research

(continued from page 48)

on Duties with regard to Nursing Functions". Out of 950 questionnaires distributed, 549 carefully completed ones were returned to us. So the starting point was encouraging.

At the beginning of August, the General Director sent a notice to each physician and to each member of the staff, officially announcing inauguration of the plan of research in the following terms: "Observers have been designated and they will circulate in the departments according to a schedule planned by the Research Division. They will record in seconds the activities of each category of the nursing personnel. The observers selected are: Rev. Sister Annette Rose, assistant director; Rev. Sister Jeanne Forest of Marguerite d'Youville Institute; Jacqueline Ouimet, assistant director of nursing; Elizabeth Bernier, supervisor in surgery; Pierrette Roy, head nurse in private rooms. The co-operation of everyone will facilitate their work which will last from 7.30 a.m. to 7.30 p.m. from Monday to Friday for two weeks. Please refrain from speaking to them during their observation periods but, on the other hand, answer their questions during the half-hour which will follow those periods. In this way, it will be easy for them to complete their observations accurately, according to instructions received from the research division."

Special meetings of departmental heads and personnel meetings were held: to explain the operation of research work; to eliminate any fear caused by these observations; to create an atmosphere of mutual trust; encourage free discussion; and finally, to promise to keep them informed of the progress of the study. The observers recorded in seconds a typical action among the daily activities of the personnel. For instance:

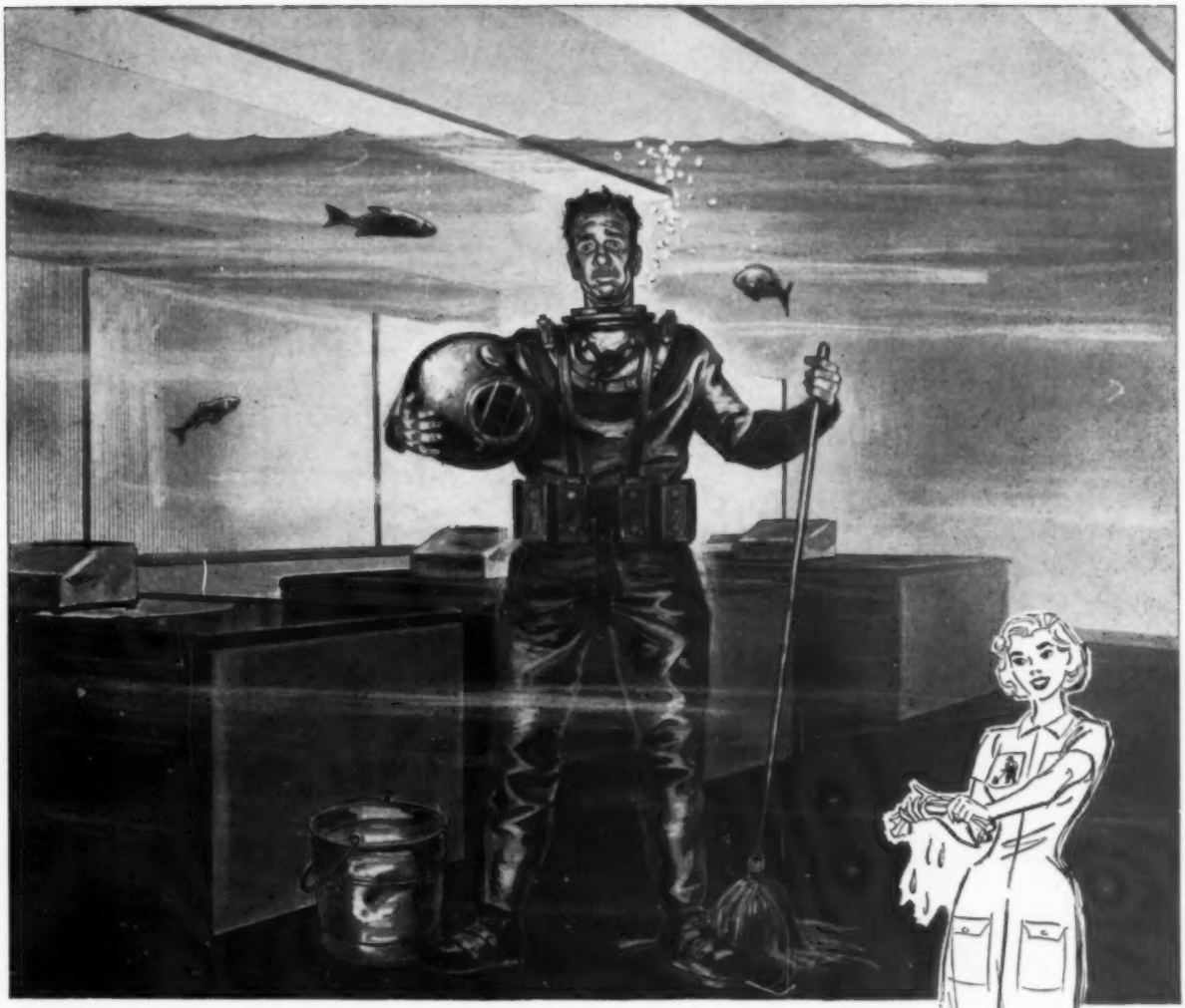
(a) Describe what the subject observed is doing or is about to do;

(b) Specify the nature of the activity being carried out;

(c) Record every instant of time spent on each observation;

(d) Reread what has been recorded at the end of each period and, if necessary, check with the person observed.

(concluded on page 84)



Is your caretaker waterlogged?

Or . . . to put it another way . . . is your caretaker merely going through the formality of swishing dirty water around, and re-distributing the dirt? More than likely this is exactly what he's doing if he's using old-fashioned, outdated equipment . . . and a wise move on your part would be to find out what a whale of a difference a "Geerpres" Wringer would make!

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Nursing Research

(concluded from page 82)

Finally, on August 27, 1956, this research plan which was to last two five-day weeks was started. The observers, perfectly trained, would appear unannounced here and there, record such or such an action, and trace the graph. Two hundred hours of on-the-spot observations, distributed over 400 periods of one half-hour each, were devoted to this study by the observers.

We may state in all sincerity that co-operation was outright and complete. Not only did this research create interest but it drew obvious enthusiasm from those participating.

It remains to code and analyze this broad study which is to serve as a guide to us in the following:

1. The organization of team work;
2. The desirable proportion to establish between professional and non-professional personnel;
3. Job analysis to make maximum use of individual talents in the distribution of work;
4. The study of standardized methods of work for greater efficiency;
5. The setting up of methods of education, explicitly defined, for all the nursing personnel;
6. The creation of joint committees of medical and nursing personnel in order to achieve simplification of routines in the care of patients.

This example will emphasize the necessity of such a simplification. In 24 hours only, 139 patients from the medical department required the following care: 255 administrations of medicines in fluid form, 644 administrations of medicines (pills), 125 i.m. injections, 38 i.v. injections, 147 blood pressure recordings, 46 administrations of sera, 4 transfusions, 6 lumbar punctures and paracentheses, 29 aerosols, 25 administrations of oxygen, 18 aspirations of secretions, 26 x-rays, 28 analyses, 57 titrations, 318 temperature recordings, 12 dressings, 12 enemas, 14 catheters, 22 suppositories, 21 patients weighed, 31 sundry treatments. Total: 1,878 administrations of medicines and treatments without counting hygienic care and diets, or an average of 13.51 per patient.

This report is only preliminary to the publication of the research results.

Recalling a well-known motto: "Illness comes at any time," we may state that that poses a serious problem to nursing. Administrative machinery implies a perfect cohesion of personnel for the benefit of the patient. That was the ideal urging us towards research, which well illustrates the ever-progressive evolution of nursing.

"Blue Cross for Doggies"

Dog owners may soon be able to buy insurance for their dogs. Tom Hughes, SPCA Vancouver shelter manager, who suggested the move, recently met with directors to discuss the plan.

Sickness will not be included in the policy. The plan will cover up to $100 for veterinary costs resulting from injuries, $100 for accidental death and $10,000 in public liability.

To get the "sort of Blue Cross plan for dogs", the owners would become members of the SPCA.

THE CANADIAN HOSPITAL

The Canadian Hospital is published monthly by the Canadian Hospital Association as its official journal devoted to the hospital field across Canada.

The subscription rate in Canada, U.S.A., and Gt. Britain is $3.00 per year. The rate for each additional subscription to hospitals or organizations having a regular subscription (and personal subscription for individuals directly associated with them) is $1.50 per year. The rate to other countries is $3.50 per year. Single copies when available, are supplied at 50c each.

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C. H. A. Directors Meet
(concluded from page 56)

general were satisfied with the present constitution. The committee, after review, had decided that no purpose would be served by offering any suggestions to the board for revision of the constitution.

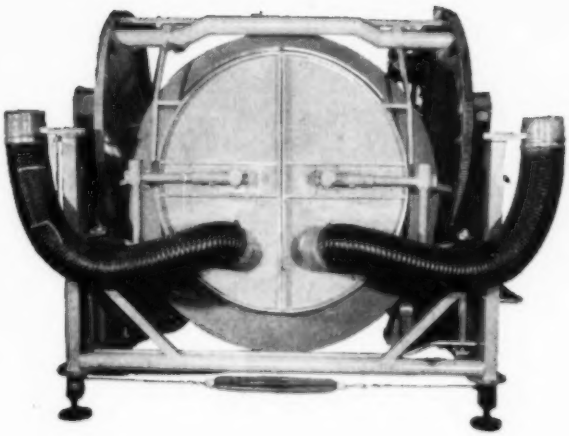
9. Approved the budget for the Canadian Hospital Association for the year 1957. As the combined budgets of the secretarial and publications funds projected a deficit of some $3,000 for the year 1957, the board directed that the executive staff in conjunction with the finance committee draw up a recommended plan of financing association activities for presentation to the next meeting of the board.

10. Extended votes of thanks to: the Royal Victoria Hospital for the use of the board room and to Dr. and Mrs. J. Gilbert Taylor for arrangements made for the directors while in Montreal; to Dr. A. L. C. Gilday, treasurer, for his work during the past year and to the executive staff.

11. Decided to hold the next Board of Directors Meeting at the Bessborough Hotel, Saskatoon, May 24th and 25th, 1957.

—W. Douglas Piercey.

Purkett PCTs* have had to be good to serve these Hospitals without complaint



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Mercy Hospital	Sacramento, Calif.
Oak Park Hospital	Oak Park, Ill.
Pontiac State Hospital	Pontiac, Mich.
Presbyterian Hospital	Chicago, Ill.
Providence Hospital	Oakland, Calif.
St. Francis Hospital	Chicago, Ill.
Stratford General Hospital	Stratford, Ont.
St. Paul's Hospital	Vancouver, B. C.
St. Vincent's Hospital	Green Bay, Wis.
U. of Oregon Medical School	Portland, Ore.
Veteran's Hospital	Ft. Lyons, Colo.

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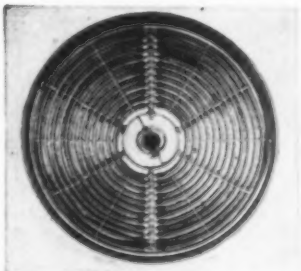

35% more heating surface with the new 12-ring coil construction.

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Joplin, Missouri
DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

Program Against Infection
(continued from page 38)

be safe with oxygen therapy, since certain plastic materials are not considered safe.

Intern Education

The intern committee included in the orientation program for all interns the techniques of scrubbing, gowning, draping, skin preparation, and a general lecture on infection control. The program was developed by the assistant director of nursing education and the operating room supervisor, in conjunction with a senior surgical staff member.

Dressing technique and charting

The director of nurses, aided by her assistants, presented a summary of the dressing technique that would be instituted throughout the nursing service. The procedure was approved by all concerned, and it was urged that immediate action be taken in instituting this in the hospital. In summary, the dressing technique presented was as follows: drape and prepare patient; wash hands; avoid reaching over sterile field, contamination of equipment, forming a wick with a wet sponge, and avoid more than one stroke with each sponge.

The chart should tell the condition of the incision at the first dressing, type of dressing applied, and by whom. The routine is the same for subsequent dressings. If there is a post-operative infection, this information should be stamped on the operating sheet and dated. In this case an infection slip is to be made out in triplicate and forwarded to the operating room supervisor, the chief of surgery, and the nursing office.

Isolation Technique

Although precautions are being taken to prevent infections from occurring, it was realistically noted that infections would undoubtedly appear from time to time and that they would require isolation technique. Since we do not have an isolation ward *per se* there would be times when transferring patients from one accommodation to another would be necessary. Also, in specific instances curtailment of visitors would be mandatory. Therefore, in order to carry out a procedure that would be effective, it was felt that a formal acceptance by the medical staff must be received.

The chief pathologist, who is both a member of the infection committee and secretary of the medical advisory council, placed the topic of isolation technique on the agenda for the following medical advisory council meeting. Needless to say, the council approved both in principle and practice the procedures that must be instituted in carrying out proper isolation technique.

Summary

During September and October of 1955, it was observed that there was an increased incidence in post-operative wound infections. The administration conferred with the chief surgeon regarding the formation of a group to examine existing facilities, equipment and procedures in the surgical areas of the hospital. This was done with the purpose of strengthening procedures in use and instituting new ones where required.

Consequently, a preliminary in-

(concluded on page 90)

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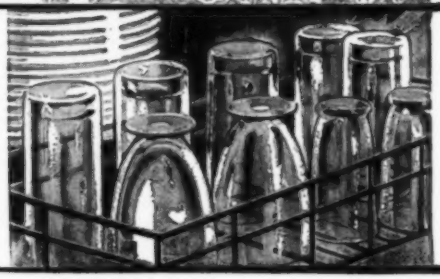

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Program Against Infection

(concluded from page 88)

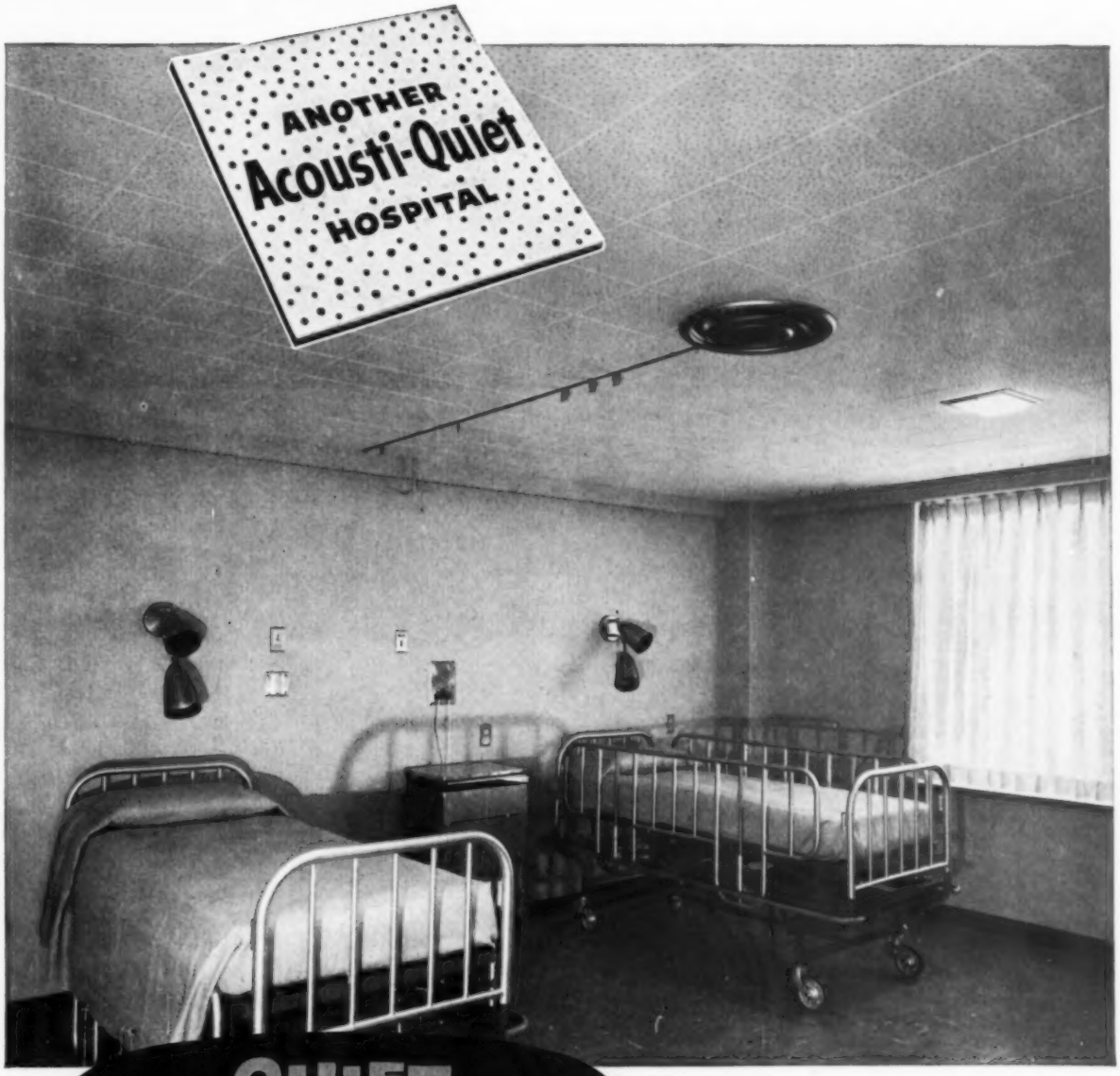
vestigation was begun involving discussions with and participation of the director of the nursing service, the surgical staff, the orthopaedic staff, and the operating room personnel. In addition, cultures were taken from equipment commonly used in the surgical areas. The results of the study revealed that some methods and procedures should be changed. Based on this study, the administrator formed the infection committee who were to be responsible for further investigation and implementation of recommendations where and when indicated. The infection committee met frequently during its early stages, formulating new procedures and reaffirming existing ones. During the period various individuals in the hospital field were consulted with a view to accumulating as much data on the problem of infection as possible. It was also concluded that the attention of the committee would not only be focused on post operative infections, but would also encompass infections occuring in non-surgical patients.

The preventive program regarding infections at the New Mount Sinai Hospital is still in progress. Certain steps have already been taken, and others will follow. We do not expect that a cure-all has been found with the institution of our preventive program; but a plan has been formulated which will serve as a base for additional planning and action.

The infection committee continues to meet once monthly to examine statistical analyses compiled from our infection slips, and to discuss new measures that can be taken to strengthen our existing program.

Double Corridor Ward Unit in Melbourne Hospital

The new Royal Women's Hospital, which is under construction in Melbourne, will have a number of interesting innovations in the field of maternity work. The double corridor ward unit will be used, and services will be completely centralized; there will be no ward kitchens or linen rooms on the ward floors. A nurses' home at the rear of the hospital will provide accommodation for 600 nurses.—*I.H.F. News Bulletin.*



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Manitoba Inclusive Rates

(continued from page 41)

represented in parts seems so to the public who generally are not completely familiar with the cost of hospital operations. Advocates of inclusive rates are of the opinion that if the public is charged a flat sum for an all-inclusive service the public will begin to realize that present charges are justified. Education of the public to the reasonableness of hospital charges will be greatly facilitated.

Current complaints about the high cost of hospital care are usually based on isolated cases where a large number of extra services have had to be rendered. Equitable distribution of these charges over all patients admitted will decrease this source of public resentment and suspicion.

It is significant that hospitals who have operated and are operating on an inclusive rate system both in Western Canada and the United States generally set out the strongest advantage of the plan to be the improvement in their relations with the patient.

Professional Relations

In other sections of this report general relationships between the physician and the patient as well as relationships between the hospital and the physician are discussed. Advocates of an inclusive rate system contend that the predictability of hospital costs improves these relationships.

One objection to such a system has been set out in that it is contended that an inclusive rate system will interfere with contract arrangements between the hospital and certain of its professional staff, including radiologists and pathologists. Experience indicates that alternative systems can be developed as a basis of contract arrangements between the hospital and professional staff. The unit system for work done in the laboratory and radiology departments can be developed to form the basis for contractual arrangement. It would not seem that any real problem exists in this regard.

Recommendations of the Committee

After review, the Committee is of the opinion that establishment of an inclusive rate system is practical and desirable for Manitoba hospitals. It is felt that the administrative load in hospitals, both large and small, would be eased materially, and that this, together with other advantages to the patient, the public, and the hospital, outweighs the problems involved in conversion to an inclusive rate system. The Committee then recommends to the Board of Directors of the Associated Hospitals of Manitoba that the establishment of an inclusive rate system in Manitoba hospitals be supported in accordance with other recommendations and conditions set out hereafter. It is also recommended that April 1st, 1957, be established as the date of conversion to an inclusive rate plan.

Type of Plan

After review of the various types of inclusive rate plans suggested, the Committee recommends that the straight line method be adopted. This plan is felt to be superior, from the hospital operating point of view, particularly since any alternative plan requires considerable financial data not readily available to most hospitals. In addition, the straight line plan would seem to have the most favorable effect on public relations.

(continued on page 96)

alarmists?

Thanks to these little fellows, you don't hear much about pyrogens any more. These rabbits work for Abbott. They serve as "alarmists" for each new batch of I.V. solutions that come off the line. It's a simple operation: We inject samples into their marginal ear veins. We wait awhile. We watch their temperatures. Any abnormal rise . . . out goes the batch. Most solutions pass the test. The point is, they *have* to pass before they can wear the Abbott label. Just another control check to make your I.V. therapy.
a little easier—and a lot safer.

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Manitoba Inclusive Rates

(concluded from page 92)

Conditions

The Committee feels that the inclusive rate plan should apply to in-patients in all hospitals as well as to out-patients in organized departments in the three teaching hospitals. An alternative system of charging for other outpatient care should be developed.

In considering the establishment of inclusive rates it was felt that contractual arrangements with third-party agencies on an inclusive rate basis should include a provision for interim review and adjustment. It was felt that this provision is essential to the success of an inclusive rate plan in Manitoba.

Inclusions and Exclusions

The Committee recommends that generally speaking, the following services should be provided under an inclusive rate plan; bed and meals, floor duty nursing, routine drugs, dressings, operating and delivery room service, clinical laboratory services, gas therapy, drug serum therapy, occupational therapy, physiotherapy, radiology, intravenous therapy, oxygen, and any other service not specifically excluded.

It was felt that exclusions would be private telephone service, appliances, guest meals, personal laundry, crutches, braces, prosthetic appliances, special or expensive drugs and private duty nursing. Detailed lists of suggested items to be excluded in some of the foregoing categories are being drawn up.

Public Relations Program

The introduction of an inclusive rate system in Manitoba would have a considerable impact on the public. It is recommended by the Committee that as much information as possible be disseminated to the public by every possible means.

The recent public relations experience of Alberta hospitals in their conversion to inclusive rates has been most favorable, but the Committee feels that the public should be as fully informed as possible before any change actually takes place.

Uniformity

The Committee feels that uniformity in the system throughout hospitals in Manitoba is of the utmost importance to the success of any inclusive rate plan. As a result, it is the recommendation of the Committee that insofar as it is possible, each hospital in Manitoba be fully informed on the matter of inclusive rates with a view to as much uniformity as possible. The Committee also feels that conversion to inclusive rates should be given careful consideration at the next annual meeting of the Association.

This is the report of the Committee on Inclusive Rates to the Board of Directors of the Associated Hospitals of Manitoba.—*T. A. J. Cunnings, Chairman,* and *R. G. Goodman, Secretary.*

New Medical Centre

A large new medical centre is nearing completion at Ponce on the island of Puerto Rico. It includes a general hospital with 434 beds, a mental hospital with a bed capacity of 1,000 and a tuberculosis sanatorium with 500 beds. There is also a school of nursing with accommodation for 200 student nurses. The centre will form a single co-ordinated entity from an administrative point of view.—*I.H.F. News.*

News Released by Hospital Supply Houses

By C.A.E.

New Type X-ray Equipment Is Modestly Priced

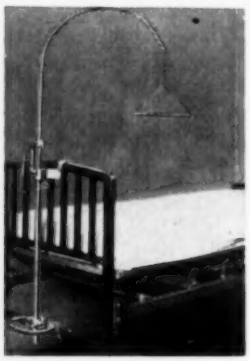
A new type of x-ray equipment that permits a physician or hospital to offer virtually complete diagnostic medical x-ray service with an investment of less than $5,000 is announced by General Electric Co., X-Ray Department, Milwaukee, Wis.

The new unit, called the Patrician, includes such features as a full length 81 in. x 27 in. angulating table, a highly manoeuverable, independent tube stand, a double focus rotating anode x-ray tube, a 200 milliampere, 100,000 volt full-wave transformer, and an automatic reciprocating Bucky grid to prevent scattered radiation from fogging the film. A foot pedal release permits tilting of the table through 105 deg. with three positive stops; 15 deg. Trendelenburg, horizontal or vertical.

The fluoroscopic screen is 12 in. x 12 in. in size, thus permitting examination of the chest and abdomen. Contoured shutter controls, instantly responsive, are shaped for ready manipulation with the gloved hand. Friction locks keep the screen in any desired position at will.

New DePuy Patient Helper

A new Improved Patient Helper, No. 670, has been introduced by DePuy Manufacturing Co., Inc., Warsaw, Ind. This unit combines the popular gooseneck style patient helper with exclusive DePuy lock-lever clamps, which assure rigid and secure clamping. The manufacturer states that one nurse can quickly and easily attach the Improved Patient Helper to practically any style hospital bed in a few moments. The rubber padded



clamps attach to head or foot portion of bed, and need not be attached at the corner posts. The gooseneck fits down into larger diameter supporting tube for greater strength. All tubing is nickel plated, electric welded steel.

The DePuy Improved Patient Helper is designed to help the patient help himself. The trapeze portion swings free so that the patient can use the unit as an aid to getting in and out of bed. It is also a valuable aid in bedpan use or getting from bed to wheel chair. The patient can change his position and do many things without the nurse's help. The trapeze can be swung back out of the way when not in use. More information concerning this new Improved Patient Helper may be obtained by writing the manufacturer.

Barnstead MF Submicron Filter

This new Barnstead Bulletin, No. 141, describes how the Barnstead MF Submicron Filter works and reveals how through this new filtering process ultra-high purity water is possible in production quantities which formerly was attained only in batch quantities in the laboratory.

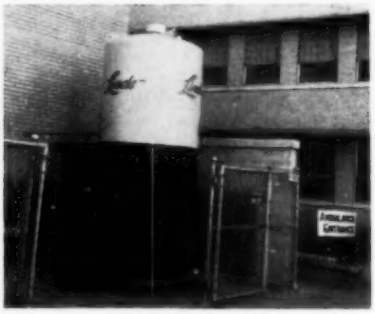
This bulletin further points up how this entirely new method of filtering either distilled or demineralized water opens up new process techniques in electronic and nucleonic fields. The filter element, because of its construction, is well suited for the analysis of impurities retained on the filter when so desired.

Other important information pertaining to the filter itself and mechanical specifications of the unit is fully told in Bulletin No. 141. Copies may be had by writing to Barnstead Still & Demineralizer Co., 171 Lanesville Terrace, Boston 31, Mass.

New Oxygen Supply Unit For Hospitals

Linde Air Products Company have introduced a new LO-90 oxygen storage unit.

An insulated cylindrical tank twelve feet high and five feet in diameter, the unit holds oxygen in liquid form under low pres-



sure at a temperature of –298°F. It contains the liquid equivalent of 90,000 cubic feet of gaseous oxygen—or the contents of about 369 standard-size cylinders. Liquid

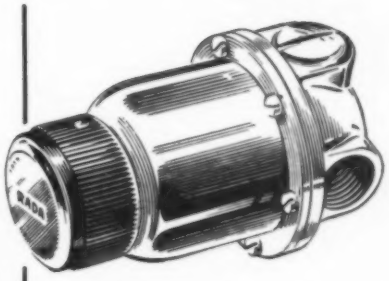
(concluded on page 100)

The coil that makes the shower a joy

Some bare facts

A shower is the best bath in the world. The skin glows in the surge and the rush of the pin-point spray. The bather screws up her face and squeaks with delight under the swift attack. But a shower must be under the control of a thermostat or it may turn a little too frisky. A Rada thermostatic valve will keep the temperature steady. It will iron out the hot or take the kick out of the cold. Rada thermostatic showers save heat, save water, save piping, and make the shower bath a delight without alloy.

Write for literature and full information to any of the addresses given below



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Across the Desk

(concluded from page 98)

oxygen is converted to a gas automatically and fed to the pipe line as needed. Installed on the hospital grounds, it is serviced by Linde, relieving hospital personnel of all responsibility for its care and maintenance.

This unit has been in production for a little over a year and already many units have been installed. Many more will be needed in the future because nearly all newly built hospitals and many existing hospitals are turning to the oxygen piping system as a more economical and efficient means than high-pressure cylinders of getting the life-saving gas to the patient's bedside and to operating rooms.

Johnson & Johnson Appointments

Johnson & Johnson Limited, Montreal, announces the appointment of Mr. T. J. Payne as Sales Representative to cover rural Manitoba and part of Winnipeg, with headquarters in Winnipeg.

T. J. Payne

J. F. Lavigne

Mr. J. F. Lavigne has been appointed as Ethicon Suture Consultant, to cover Eastern and Northern Ontario, with headquarters in Ottawa.

With Stevens Companies

M. L. (Mert) Bourke has been appointed one of the Stevens sales-service representatives in the Province of British Columbia.

M. L. Bourke

Mr. Bourke graduated from the University of Saskatchewan with a B.Sc. degree in Pharmacy. He is widely known to physicians, druggists and hospital personnel in British Columbia, having formerly represented a pharmaceutical firm in that territory.

Conversion Adapter Cover

A new conversion unit which transforms any standard 55 gallon drum into a vacuum cleaner tank is being introduced in Canada by G. H. Wood and Company, Limited.

The assembly, named the Clarke Giant Conversion Unit, offers the cleaning capacity of a large wet-dry vacuum cleaner at exceptionally low cost. It consists of an air intake and exhaust unit powered by a 1 H.P. motor, inside filter bag, and conversion adapter cover which fits any standard 55 gallon drum.

Attaching the unit requires no alterations of the drum. The unit is simply placed on the open top of the drum and held securely by the vacuum.

According to the manufacturer, users of the Model WD-23 Clarke Vacuum Cleaner can easily convert it to a large capacity drum tank unit by simply attaching the motor head assembly to the drum top with the new Conversion Adapter Cover.

Additional information is available from G. H. Wood and Company, Limited, P.O. Box 34, Toronto 14, Ontario.

Keith Little Joins Architectural Firm

Govan, Ferguson, Lindsay, Kaminker, Langley, Keenleyside, Architects, Toronto, announce that Mr. Keith Little will join the firm on January 2nd.

Mr. Little has been associated with the Wrought Iron Range Company for a number of years. He will be available for consulting work on kitchen layout, equipment, equipment specifications, and food service planning of all kinds.

Mr. Little has had wide experience in consulting work in the past for institutions and industry. He has an extensive knowledge of equipment production, and installation, and his experience and ability will be available to their clients.

New Dustbane Product

An improved new product, anti-slip Dura Life floor finish, developed for the safe, economical maintenance of all types of floors, has been introduced by Dustbane Associated Companies.

A non-flammable water emulsion product containing no wax, Dura Life is recommended for use on asphalt, rubber, linoleum and cork tile, and linoleum.

In addition to its important slip-resistant qualities, this new floor finish is self polishing; water, grease and scuff resistant; long wearing, easy to apply and remove.

Dura Life floor finish dries quickly—within 20 minutes or less—to a high gloss which does not fade or smear with traffic.